WOMEN'S ATTITUDES TOWARD THEIR PARTNERS' INVOLVEMENT IN ANTE-NATAL CARE SERVICES AND PREVENTION OF MOTHER – TO – CHILD TRANSMISSION OF HIV IN QUTHING DISTRICT

by

Oluwasola Afolabi Abiodun

Assignment presented in partial fulfillment of the requirements for the degree of Master of Philosophy (HIV/AIDS Management) in the Faculty of Economics and Management Science at Stellenbosch University

Supervisor: Dr Thozamile Qubuda

April 2014

DECLARATION

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole owner of the copyright thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

February 2014

ABSTRACT

BACKGROUND: HIV and AIDS remains a public health challenge in Sub-Saharan Africa even though the epidemic has stabilized worldwide. The key strategy to prevention and control of HIV remains voluntary counselling and testing. Mother-to child transmission accounts for over 95% of all paediatric HIV infections worldwide. It is estimated that, in Sub-Saharan Africa, 76% of pregnant women have at least one antenatal care. In Quthing district, mother to child transmission of HIV accounts for 36% of all paediatric HIV infections in 2010 while HIV prevalence of women of child bearing age stands at 26%. Consequently, antenatal care is an avenue through which the women can have HIV testing, and, if she is infected, will be provided with care so as to prevent transmission of HIV from the mother to the child (PMTCT).

The ministry of health, Lesotho in collaboration with Non-governmental organization have advocated increase in the number of men tested for HIV through partner testing in antenatal care. Health care practitioners are often required to care and treat these women when they present for antenatal care. It is essential to determine their knowledge and risks of transmission of HIV and their attitudes towards their patient and their partner involvement in antenatal care and PMTCT. Recent survey has shown that African women may not be willing to accommodate their partner's involvement in antenatal care due to cultural and traditional factors.

METHODS: The study surveyed women to identify their attitudes and beliefs concerning antenatal care, partners' involvement in antenatal care and testing, PMTCT and to identify the attitude of MCH staffs to male partner involvement in antenatal care. This study elicited data from 25 pregnant women and nursing mothers and 10 staffs of maternal and child health of Quthing district hospital. Two types of data were collected namely: self-administered questionnaire with 25 women and semi-structured interview with 10 staffs of MCH.

RESULTS: What came out clearly is that women viewed antenatal care as important to having good pregnancy result and they see it as an avenue to get tested. Majority of the women (68%) were in support of their partners' involvement in antenatal care. The staffs of MCH were in total support of this. Cultural factors and gender based beliefs were found to be hindering male

involvement in PMTCT programme and getting tested for HIV. The results also show that the staffs of MCH have positive attitudes towards people living with HIV.

DISCUSSIONS: Although, pregnancy has traditionally been viewed as a woman's affair, a good number of women expressed the desire to get their partners' involved in antenatal care, including HIV counselling and testing. Majority of the women see antenatal care as a way to having a successful pregnancy and have identified male involvement down to individual beliefs. The researcher suggests improvement in antenatal care services and provision of a comprehensive approach to community mobilization of men. Further, ministry of health could assist in improving the knowledge of health professionals on HIV and AIDS related matters through the implementation of continuous professional development courses.

OPSOMMING

AGTERGROND: MIV en vigs is steeds ŉ uitdaging vir openbare gesondheid in Afrika suid van die Sahara, hoewel die epidemie wêreldwyd bestendig het. Die vernaamste strategie vir die voorkoming en beheer van MIV bly vrywillige berading en toetsing. Moeder-na-kind-oordrag verteenwoordig meer as 95% van alle gevalle van pediatriese MIV-infeksie wêreldwyd. Na beraming kry 76% van swanger vroue in Afrika suid van die Sahara minstens een keer voorgeboortelike sorg. In die Quthing-distrik van Lesotho het MIV-oordrag van moeder na kind 36% van alle gevalle van pediatriese MIV-infeksie in 2010 verteenwoordig, terwyl MIV onder 26% van vroue in hulle vrugbare jare voorkom. Gevolglik is voorgeboortelike sorg ŉ kanaal waardeur vroue vir MIV getoets kan word en, indien hulle geïnfekteer is, VMKO-behandeling kan ontvang (wat voorkom dat MIV van moeder na kind oorgedra word).

Lesotho se minister van gesondheid, in samewerking met nieregeringsorganisasies, staan dit voor dat meer mans vir MIV getoets word deur die betrokke man ook tydens voorgeboortesorg te toets. Gesondheidspraktisyns moet dikwels vroue behandel wat vir voorgeboortesorg aanmeld. Dit is noodsaaklik om vas te stel wat sulke werkers weet van MIV-oordrag en hulle risiko van infektering, en wat hulle ingesteldheid is teenoor hulle pasiënte en die betrokkenheid van pasiënte se maats by voorgeboortesorg en VMKO. ŉ Onlangse opname het getoon dat swart vroue in Afrika weens kulturele en tradisionele faktore onwillig mag wees dat hulle maat by voorgeboortesorg betrokke raak.

METODES: Die opname is onder vroue gedoen om te bepaal wat hulle ingesteldheid en oortuigings is rakende voorgeboortesorg, ŉ maat se betrokkenheid by voorgeboortesorg en toetsing, en VMKO; die opname wou ook bepaal wat MKG-personeel se ingesteldheid is teenoor manlike maats se betrokkenheid by voorgeboortesorg. In hierdie studie is data ingesamel van 25 swanger vroue en moeders wat borsvoed, en van 10 personeellede in die moeder-en-kind-gesondheid-afdeling van die Quthing-distrikshospitaal. Twee soorte data is verkry: ŉ selfdoenvraelys van die 25 vroue en semi-gestruktureerde onderhoude met die 10 MKG-personeellede.

BEVINDINGS: Die navorsing het bevind dat vroue reken voorgeboortesorg is belangrik vir ’n voorspoedige swangerskap, en hulle beskou dit as ’n manier om getoets te word. Die meeste vroue (68%) was ten gunste daarvan dat hulle maats by voorgeboortesorg betrokke moet wees. Alle MKG-personeellede was ten gunste daarvan. Daar is bevind dat kulturele faktore en oortuigings wat op gender gegrond is mans verhinder om by die VMKO-program in te skakel en hulle vir MIV te laat toets. Die bevindings toon ook dat MKG-personeel positief ingestel is teenoor mense wat met MIV leef.

GEVOLGTREKKINGS: Hoewel swangerskap tradisioneel as vrouesake beskou is, het heelwat vroue gesê dat hulle graag wil hê hulle maats moet by voorgeboortesorg betrokke wees, en ook MIV-berading en -toetsing ontvang. Die meeste vroue beskou voorgeboortesorg as ’n manier om ’n suksesvolle swangerskap te hê, en verbind die betrokkenheid van manlike maats met persoonlike oortuigings. Die navorser beveel aan dat voorgeboortesorgdienste verbeter word en dat ’n omvattende benadering gevestig word om die mans in die gemeenskap te betrek. Verder sou die minister van gesondheid ook kon help om gesondheidswerkers se kennis van MIV- en vigsverwante sake te verbeter deur kursusse vir voortgesette professionele ontwikkeling in te stel.

TABLE OF ABBREVIATION AND ACRONYMS

The abbreviations, acronyms and terms, are used throughout the dissertation. They are listed here for reference and clarity.

ART - Antiretroviral treatment clinic
ARVs - Antiretroviral
CPDS – Continuous professional development seminars
HIV – Human immune deficiency virus
EGPAF – Elizabeth Glazer paediatric AIDS foundation
ICAP – International centre for AIDS care and treatment
MCH – Maternal and child health
MTCT – Maternal to child transmission
NGOs – Nongovernmental organizations
PMTCT – Prevention of mother to child transmission
STIs – Sexually transmitted infections
TB – Tuberculosis
UNAIDS – The joint United Nations programme on HIV and AIDS

DEFINITION OF TERMS

HIV (Human Immuno-deficiency Virus) is the virus that destroys the immune system and renders the person susceptible to infections (Whiteside & Sunter, 2000).

AIDS (Acquired Immunodeficiency Syndrome) is "the presence of a reliably diagnosed "opportunistic" disease and of the underlying defect in cell mediated immunity in the absence of known causes of immune defects such as immunosuppressive therapy or malignancies" (Onin, 2002).

Knowledge "is the ability to acquire, retain and use information; a mixture of comprehension, experience, discernment and skill" (Badran, 1995).

Attitude refers to inclinations to react in a certain way to certain situations, to see and interpret events according to certain predispositions or to organize opinions into coherent and interrelated structures (Badran, 1995).

The risk factor is the harm that is caused by some particular danger or threat. These factors exist before a problem arises or continue over time. A community or the general environment can contribute towards the problem (Skolbekken, 1995).

PMTCT refers to the prevention of mother to child transmission of HIV during pregnancy, at birth and throughout the developmental milestone of the child

TABLE OF CONTENTS

Chapter 1

1.1 Introduction

In Lesotho, the rate of HIV transmission has stabilized over the years as vast number international organizations; local organizations and government are working to prevent the spread of HIV/AIDS and prevent the transmission of HIV from the mother to the unborn child. In 2009, it was estimated that around 72% of the people that succumbed to AIDS happened to come from Sub – Saharan Africa (UNAIDS, 2010). In Lesotho, the advent of AIDS has impacted on the community thereby shortening the life expectancy of the population. It is worth saying that sub – Saharan Africa continues to carry most of the burden of this pandemic, while, the infection has stabilized; death due to AIDS continuously occur, and the epidemic still remains a challenge.

Lesotho is a country located in the southern part of Africa where it is entirely landlocked by South Africa. The country has ten areas occupying a total area of about 32,355 (sq.). Kilometres (LDHS, 2009). The population is made up of two areas that could be called urban and countryside which in turn are sub – divided into four ecological zones; lowlands, foothills, mountains, and Senqu river valley. Quthing is a district located in the senqu river valley, and the main public hospital is the Quthing government hospital, providing in-patient and out-patient services.

The inpatient services care includes surgical, medical, paediatric, obstetrics and gynaecology, TB wards. The obstetric wards provide on average, total of 234 deliveries per quarter. The hospital offers outpatient services to the people of the region and its environs. The outpatient services include dental services, primary services, ART services, and emergency care. Ante natal services are held three times a week, with an average of 39 women attending weekly (E. Ziyachesa, personal communication, 9 April 2013).

HIV is transmitted through different means. However, majority of transmission occur through heterosexual contact. The presence or absence of sexually transmitted infections (STIs) in either

of the partner increases the risk of being infected. Male circumcision has been implicated in the spread of HIV. It is said that male circumcision reduces the chances of being infected by 60% (LHDS, 2009). HIV could also be transmitted from the mother to the child through heterosexual contact, or during pregnancy, at birth, and through breast feeding. Programs aimed at prevention of mother to child transmission (PMTCT) are implemented to curb the spread of HIV in Lesotho.

In 2006, ICAP won the funding to establish PMTCT program in Lesotho from USAIDS. The program was started in all the districts, and in 2009, Elizabeth Glazer Paediatric AIDS foundation won the funding from USAIDS to continue with the implementation of PMTCT. Quthing government hospital has integrated PMTCT program in its ante – natal services. Staffs of maternity, MCH, ART, and pharmacy are involved in the implementation of the PMTCT program. The staffs provide on-site services as well as providing services to the health centres.

As part of integrating all the services, HIV counselling and testing has always been made available to the partners of the pregnant women. In Quthing district, it is of serious concern that the partners of the pregnant women are not availing themselves of these services despite numerous strategies. The result is that fewer men engage in ante – natal services and, therefore, unable to receive HIV counselling and testing.

The reason advanced to reduce male involvement in ante –natal service is believed to be cultural. Some of the staffs are of the belief that women themselves may not be disposed to or accept partners' involvement in their ante – natal care. It is with this realization that, it is necessary to find out the women's perception and beliefs towards their partners' involvement in the ante – natal services and prevention of transmission of HIV to the child by the mother in Quthing district in "Lesotho".

1.2 Problem statement

Sadly, despite the roll out of the PMTCT program in Quthing district, we continue to experience HIV related morbidity and mortality among pregnant women and also, transmission of HIV infection from mother to child. With an increasing number of pregnancies and deliveries being

recorded, it is crucial that men should be encouraged to play a greater role in the ante – natal care services of their women.

Public health organizations have advocated increasing HIV testing of men by incorporating partner testing into ante – natal care services. The turnouts of men accompany their women are still low in Quthing district. This is a serious problem in Quthing community hospital as it is possible for the pregnant women accessing ante – natal care services to be infected during the course of their pregnancy. These women may likely spread the HIV to their unborn child. It remains to be seen whether women will influence their partners to participate fully in their ante – natal care services.

1.3 Research question

The research that I would like to answer is "what are the women's attitude towards their partners' involvement in ante – natal care services and in the prevention of mother to child transmission of HIV in Quthing district?" 'According to Christensen (1985:59), the statements of the problem need to be formulated in a way that the research question satisfies Kerlinger's definition of an interrogative statement'. The question being asked is 'what relationship exist between two or more variables?' In the light of the above, a good research question should be able to meet the following criteria:

- There should be variables in the problem expressing relation
- The problem should be in the form of a question.

In seeking a solution to the problem, the aim is to establish women's attitude to their partners' participating in ante – natal care. It is necessary to identify women's perception and beliefs with a view of understanding their attitude towards male participation. This will help unravel some of the barriers that prevent male partners' from accessing ante – natal care services with their women.

1.4 Significance of the study

Although, the prevalence of HIV in Lesotho since 2004 has remained unchanged, there are small increases seen in Quthing district. The study is significant in that it may help the Women accessing ante – natal services as it may help bridge the gap in helping their partners attend ante – natal services with them. This may help reduce the risk of contracting HIV infection during pregnancy and limiting the incidence of mother to child transmission of HIV. The study may also help Quthing government hospital as it may help improve ante – natal care services with the goal of providing comprehensive care for the pregnant women and their partners.

1.5 Aims and objectives

1.5.1 Aim of the study

The aim of the study is to identify HIV positive women and their partners' involvement in their ante – natal care services in order to prevent HIV transmission from the mother to child.

1.5.2 Objectives of the study

The study will strive to answer the following objectives:

- To analyse the extent to which existing ante – natal care services supports male participation
- To establish women's knowledge and use of HIV care
- To establish the women's attitude towards their partners' attending ante – natal care services with them.
- To provide recommendation where possible towards encouraging male participation in ante – natal care services with their women

1.6 Definition of terms

HIV (Human Immuno-deficiency Virus) is the virus that destroys the immune system and renders the person susceptible to infections (Whiteside & Sunter, 2000).

AIDS (Acquired Immunodeficiency Syndrome) is "the presence of a reliably diagnosed "opportunistic" disease and of the underlying defect in cell mediated immunity in the absence of known causes of immune defects such as immunosuppressive therapy or malignancies" (Onin, 2002).

Knowledge "is the ability to acquire, retain and use information; a mixture of comprehension, experience, discernment and skill" (Badran, 1995).

Attitude refers to inclinations to react in a certain way to certain situations, to see and interpret events according to certain predispositions or to organize opinions into coherent and interrelated structures (Badran, 1995).

The risk factor is the harm that is caused by some particular danger or threat. These factors exist before a problem arises or continue over time. A community or the general environment can contribute towards the problem (Skolbekken, 1995).

PMTCT refers to the prevention of mother to child transmission of HIV during pregnancy, at birth and throughout the developmental milestone of the child

1.7 Research design and methods

The study will be conducted in Quthing district, and it will involve both quantitative and qualitative methods in gathering data. The attitude of women to their partners' participating in ante – natal care services will be assessed. A convenience sample will be used. Participants will be interviewed for eligibility criteria. The eligibility criteria will be that the women selected must be pregnant or formerly pregnant. They should be above eighteen years and HIV positive. The target group will be based on the above criteria and a total of twenty five participants will be selected. Participants will be recruited when they come to ART clinic for treatment during the course of their ante-natal care services by staffs of maternal and child health. The clinic is solely for people living with HIV.

It will be explained to the participants that no identifying information will be collected; no penalty for non-participation and questions could be responded to or, not as the participant wish. No incentive will be given, and participants will be interviewed face to face in private. Anonymous code number will be given to the participants who will not relate to the participant's information. The questionnaire will consist of both closed and open ended questions. The answers will be categorized into probable responses, an "other" answer space, and a "do not wish to answer" variable. The questionnaire will be administered after informed consent and responses will be recorded. The questionnaire will be verbally administered, and it will be in English and Sotho. Responses will not be prompted, and the participants will be given options for selection. Questions will be constructed for the questionnaire after relevant literature search. A pilot study will be conducted to test run the questions. This will involve four pregnant women. The aim is to determine the appropriateness and clarity of the questions. Questions will be asked on their knowledge of HIV and how it is transmitted. Inputs will be obtained from the PMTCT staffs, and the questionnaire will be modified where necessary.

A semi structured interviewed guide with open ended questions will be held for the ten staffs maternal and child health department (MCH) of Quthing government hospital in an attempt to get their perspective. The question will relate to the topic being investigated and findings will help make an informed discussion. The information collected will be analysed and safely stored so that individuals do not have access to them.

1.8 Structure of the study

The first chapter attempts to provide a background of the problem of the rate of transmission of HIV in Sub – Saharan Africa, and subsequent deaths due to AIDS. The chapter describes the challenge the epidemic has posed to the people of Quthing district and the response from the government and non- governmental organizations in Lesotho. In response to this challenge, male partners of pregnant women are encouraged to access antenatal care services with their spouses. The chapter provided a brief summary of some of the factors militating against this. The chapter also outlines some of the factors fuelling the transmission of HIV and outlines the objectives and significance of the study.

Chapter two provides details of preliminary literature review with a view to understandings findings from other studies with regards to women's attitude to their partner accessing antenatal care services and prevention of mother to child transmission of HIV. The chapter explores the conceptual framework of vulnerability and risks in the context of HIV and AIDS. In order to understand the concept of antenatal care and prevention of mother to child transmission, the chapter explains voluntary counselling and the different PMTCT interventions. The barriers to the male partner involvement in prevention of mother to child transmission and facilitators of male involvement in prevention of mother to child transmission of HIV were explored.

Chapter three outlines the research methodology used in conducting this study with specific reference to subject selection, measuring instruments and data collection methods. The two instruments used for data collection in the study are questionnaires and semi structured interviews which are explained in detail with steps and methods employed to adhere to ethical requirements and ensure confidentiality and rights of participants are observed and protected.

Chapter four provides in-depth critical analysis of data that was collected through the study. Analysis of the data aimed at identifying women's' attitude with regard to their partner accessing ante-natal care services with them, the challenges and how the information may help in improving male attendance in ANC clinic

In the last chapter five, the summary of the thesis, limitation of the study, conclusions from the study are drawn and inferences from results made in order to make recommendations where appropriate

Chapter 2: Critical literature review

2.1 Introduction

In other to gain an understanding of the current state of HIV and AIDS trends in the Sub – Saharan Africa, the researcher conducted a preliminary literature review that attempts to give a brief summary of the epidemic patterns, health care provision especially maternal services and prevention of mother to child transmission. The study also sought to explore concepts relating to health care worker's knowledge of HIV and AIDS towards the provision PMTCT services, their attitude towards it, their fears and risk of HIV transmission at workplace. It also examines barrier to male involvement in prevention of mother to child transmission of HIV and facilitators of PMTCT.

2.2 Overview

It was estimated that 72% of AIDS death that occurred worldwide in 2009 occurred in Sub – Saharan Africa (UNAIDS, 2010). Heterogeneous epidemic patterns have emerged with the 3 Sub – Saharan regions with proportions of persons living with HIV ranging from 24.9% to 27% in Southern Africa, 3 – 7% in East Africa and 2 – 5.3% in West Africa. Lesotho has one of the highest prevalence in Southern Africa at 23.6% (UNAIDS, 2010).

Healthcare provision varies considerably throughout the world. There are many influences in the provision and take up of health care, especially maternal services such as antenatal care and measures to prevent HIV transmission between the mother and child. Research in the past has looked at several influences. Social influences have known to play a role. For example, research has indicated that perceived social roles may impact on the way care is, or is not sought. For example, Sauerborn, Noutgtara and Latimer (1994); found "in developing countries", a barrier that prevented maternal care to be sought before and after birth was the women's self-perception being that their health needs were less significant compared to other family members, mostly male family members.

2.3 Conceptual framework

The conceptual framework of vulnerability and risk, according to Mann and Tarantola (1996), fear, according to Hodgson (1997), formed the basis of the study of knowledge and attitudes. The framework also included concepts of knowledge attitudes. The concept of individual and collective vulnerability has come up as one of the theoretical perspectives used to describe the occurrence of HIV/AIDS among individuals and partners.

Mann and Tarantola (1996) & Koning and Kemp (1998) defined vulnerability to HIV infection as a variety of circumstances, which renders an individual or community vulnerable to HIV infection, inadequate care and societal support. The concept of vulnerability provides a comprehensive model for examining risk taking behaviours, recognizing the risk – taking behaviours and understanding them. There are a number of complex factors at work in the formation and manifestation of attitudes of women towards their partner participating in antenatal care services with them.

Their reluctance to involve their partners is based on exaggerated fear of divorce, accusation of unfaithfulness or been the direct cause of the infection. There is thus over cautiousness due to the fear of stigmatization in case the woman was found to be HIV positive. Their reluctance also stems from the fear of being subjected to domestic violence. These may have prevented the women from bringing their male partner for counselling and testing.

2.4 Antenatal care and prevention of transmission of HIV from the mother to child

Transmission of HIV to the child is when an HIV positive mother passes the virus to the child during pregnancy, labour, delivery, and during breastfeeding. About 1.5million HIV positive women became pregnant each year. In the absence of antiretroviral, there is the likely hood of 15 – 45% chance that the child will also be infected. However, the risk of transmission from the mother to the child is less than 5% among mothers on ARV's regimen (UNAIDS, 2010).

It was estimated that 230,000 children died from AIDS in 2011 while around 330,000 under the age of 15 becomes infected around the same period. Most of these infections occur in Sub – Saharan Africa, and it was as a result of the mother to child transmission. However, this scenario can be averted, and in high income countries, the incidence of mother to child transmission has been eliminated entirely. This is due to the high rate of voluntary counselling and testing services, access to antiretroviral, safe delivery practices and widespread availability of medication. Globally, around 370,000 infections has been avoided since 1995 due to several interventions (UNAIDS, 2010).

2.5 Voluntary counselling and testing

Voluntary counselling and testing of couples enables them to learn about their condition. This will help design interventions that will meet their needs in an environment that is supportive, and where accurate information will be given (CDC, 2007). Many public health or organizations have encouraged individual man and couples testing in antenatal care as one strategy to increase HIV testing in men. We continue to experience low male turnout in programs that have incorporated male counselling and testing into their antenatal care services (WHO, 2007).

2.6 PMTCT interventions

The provision of PMTCT interventions relies on so many factors. These factors depend on complex decision – making involving both partners. Involvement of both partners appears to encourage participation in health care programs to including PMTCT (Bolu, Allread, Creek, Stringer, Foma & Bultleys, 2007). This is vital in Sub – Saharan Africa where decisions regarding reproductive health are profoundly influenced by males. Mlay, Lugina and Becker (2008); found out that the patriarchal nature of the most African culture and economic dependence of most women allow their male partners to dictate what happens in their reproductive health. They also played a role in female vulnerability to HIV during pregnancy (Peltzer, Jones, Weiss & Shikwane, 2011). Reports have pointed to the advantages of involving male partners in antenatal HIV care services of their spouses and on prevention of HIV transmission to the child from the mother. A number of studies have been conducted pointing to

the beneficial involvement of the male partner in prevention of transmission of HIV to the child from the mother. One of these studies was conducted in East Africa by Aluisio, Richardson, Bosire, John – Stewart, Mbori – Ngacha and Farquahr (2011); which provided empirical support to male involvement with PMTCT services.

The ability of the male partners to control their female spouses will go a long way to influence the thinking and willingness of women to adapt to any products. It is imperative that there is cooperation between the couples involved as regards PMTCT services and prevention of vertical and horizontal transmission of the virus (Baides, Remes, Baiden, Williams, Hodgson, Boelaert & Buve, 2005). Aarnio, Olsson, Chimbiri and Kulmala (2009); found out that the absence of male involvement in PMTCT interventions poses a serious challenge to the potential benefits of HIV prevention in antenatal services. Thus, lack of male involvement represents a missed chance, to tackle vertical transmission of HIV. Therefore, it could be said that male partners are being left behind in the equation (Mohala, Bolly & Gregson, 2011).

2.7 Barriers to the male partner involvement in PMTCT

2.7.1 Societal or cultural factors

This may be one of the reasons why male involvement in antenatal service with their partners is reduced. Nkuoh, Meyer, Tih and Nkfusai (2010); found out that the general societal impression was that antenatal services is a woman's activity, and it was unthinkable for a man to be found in such settings. This cultural barrier may serve to demotivate men. In most African settings, it is against the norm for women to lead. In these settings, it is out of character for a man to listen to the woman, and it is difficult to conform to what a woman says (Falnes, Moland, Tylleskar, De Paoli, Msuya & Engebretsen, 2011). The traditional cultural environment does not allow women to take decisions on the home front. These include matters that involve health care such as antenatal care and HIV counselling and testing. This serves as a major obstacle to women's effort involving their spouses in PMTCT.

Nkuoh (2010); found out that culture may be a barrier in allowing both men and women to express themselves. Lack of communication could be a factor in the male not engaging their

partners in sexual related topics. Such topics include attending antenatal services with their partners and participation in PMTCT services. The general perception is silence and lack of complaints from both parties. This is to give the impression that all is well within the family and also to highlight the domineering nature of the male partners in the relationship.

2.7.2 Male individual factor barrier

The difficulty in getting males to get tested and know their status was a significant impediment to male involvement in ANC/PMTCT involvement. This was reported in 25% of studies conducted (Aanio, Olssson, Chimbiri & Kulmala, 2009). Many theories have been adduced to the difficulty in getting males tested. One of them is the possibility of being HIV positive resulting from fear of the unknown (Kizito, Woodburn, Kesande, Ameke, Nabulime, Muwanga, Grosskurth & Elliot, 2008). While "for others", the problem was the difficulty in accepting one's status if it is positive (Mbonye, Hansen, Wamono & Magnussen, 2009). Stigmatization of those who is HIV positive was one of the factors associated with male reluctance to get tested (Kizito, et al 2008).

The second barrier was the time factor. The timing of ANC/PMTCT activities could be in conflict with men's normal daily activities. There is no time for men to participate in ANC services, and receive knowledge useful to implement PMTCT strategies. Male understanding of his own health was also seen as an obstacle to their participation in PMTCT. Interesting findings were the notion of male about their health as being sound. This constitutes a significant barrier to participation of male in ANC/PMTCT. The self-perception of good health was seen as an impediment to getting involved in ANC/PMTCT services. This is because the initial step to getting involved is to be tested, and the result of your HIV known.

2.8 Facilitators of male involvement

There are so many facilitators of male PMTCT involvement. Some of which are:

2.8.1 Health system facilitators

Most of the interventions which encourage male participation in ANC/PMTCT has been attributed to health systems interventions. The use of invitation letters from the health centres encouraging men to participate in ANC/PMTCT was identified as a catalyst in male involvement in, antenatal care services, by the majority of the studies conducted (Byamugisha 2011; Ditekemena, 2011; Fanes, 2011). Wall, Karita, Nizan, Bekan, Sardar, Cassanova, Deborah, Davey, Davora, De Clerq, Freya, Bayingana and Roger (2012); found out that; invitation letters given by influential agents within the community to the spouses are effective. The view held by the people was that these letters are essential and are seen as an alternative to medical prescription encouraging them to attend. The most significant catalyst in encouraging male participation, therefore, appeared to be the invitation letters.

The place where voluntary counselling and testing for HIV was offered seemed to help men access antenatal services with their partners (Jasseron, Mandelbrot, Dolfus, Trocme Tublana, Teglas, Faye, Rouzioux, Blanche & Warszawski, 2011). Such setting may include bars, churches or even their job sites was seen as a major facilitator to male involvement (Nkuoh, Meyer, Tih & Nkfusai, 2010). A further facilitator of male involvement was differential targeting and offering voluntary testing and counselling to men who followed their partners to the delivery ward (Semrau, Kuhn, Vwalika, Kasonde, Sinkala, Kankasa, Shutes, Aldrovandi & Thea, 2005). It was found that these men were encouraged by the well-being of their wives and future babies. Involving them may serve as one of the entering point in encouraging male involvement in participating in antenatal services and prevention of HIV transmission to the child from the mother.

2.8.2 Relationship dynamics facilitators

Study conducted on the relationship dynamics found out that certain factors within the partnership encouraged male partner participation in ANC/PMTCT. It was found out that marriages or the co – habitation of partners facilitated male partner's involvement in ANC/PMTCT (Aluisio, Richardson, Bosire, John-Stewart, Mbori-Ngacha & Farquhar, 2011). This aspect of the relationship brings to the fore its importance providing stability and better quality as well as encouraging partners talking about issues that affect them.

Another facilitator of male involvement in PMTCT was found to be Partners opening up about it. This was found to be the case in one of the studies conducted (Shankar, Pisal, Patil Joshil, Suryavanshi & shroti, 2003). It was found to be independent of marital/cohabitation status. Engagement by both partners encourages joint decisions and their participation in accessing antenatal care services and prevention of mother to child transmission of HIV.

2.9 Health care workers knowledge of HIV and AIDS

"Knowledge is the capacity to acquire, retain and use information" (Badran, 1995). These are the facts, information, skills and understanding that have been gained especially through learning and experience. It is important for the staffs of maternal and child health to be well equipped with current facts, information on treatment and knowledge of the prevention of mother to child transmission of HIV. The knowledge and use of universal precautions (UPs) by these health care workers, when caring for pregnant women, were imperative in the prevention of the spread of HIV/AIDS (Shearer & Davidhizar, 1999). All health workers are deemed to encounter PLWA (UNAIDS 2003b) and therefore face the occupational risk of HIV transmission in the workplace. Staffs working at maternal and child health department are part of the interdisciplinary team that will care for the patient with multiple problems, especially in the prevention of mother to child transmission of HIV.

Therefore, they need to be well informed and knowledgeable about HIV and its transmission and prevention as they are an important source of information for their patients. The knowledge level held by the staffs can affect their service delivery, and it is necessary so that they can provide adequate treatment (Buskin et al, 2002; Souheaver, et al, 1996). It is believed that the only way now to reverse the epidemic, without a vaccine in place, is through public education on the prevention of HIV/AIDS infections. The health profession bears much of this responsibility (Mungherera, Van der Straten, Hall, Faigeles, Fowler & Mandel, 1997). Information on HIV/AIDS demographic and epidemiological patterns serves as the foundation for the primary interventions utilized in public health, namely prevention (Caldron, 2001).

Unfortunately, it has been found that health care professionals have less than accurate knowledge of the modes of transmission, their own risk of contracting the infection and on AIDS symptoms (Gatsi, Amosun & Mhlanga, 1994). Since HIV/AIDS is now a chronic disease, these patients may still have many months or years of productive life. These patients will spend some quality time with the staffs of maternal and child health department during the course of accessing ante-natal care services, which in turn gives the therapist ample time to discuss the HIV/AIDS disease with them. This puts the staffs in the role of a counsellor, imparting knowledge and reassuring the client. This relationship is pivotal in establishing an open, trusting and collaborative relationship. It also offers reassurance and comfort to the patient and opens ways of obtaining information from the patient (Soon, 2002). It has been observed that failure to establish this relationship is associated with poor treatment outcomes (Lambert, 1989).

The survey was conducted by Mungherera et al, (1997) on a consecutive sample of 90 doctors and 78 nurses in Uganda, to determine HIV/AIDS related attitudes and practices. This study concluded that there was a need for intervention to address the gaps in knowledge. The study revealed that patients did not benefit from educational talks by nurses because of the latter's lack of knowledge. Other Studies that were done to assess HIV knowledge of HCWs have found the following. Pilyugina Katzenstein, Bergen, Usichenko, and Shapiro (2000) had a sample of 321 HCWs, and they used an anonymous questionnaire. Forty eight percent of the workers rated their HIV knowledge as moderate to sufficient; 89% requested for further training. These results suggest that there was a need for an increase in education and implementation. A similar study was done on nurses' attitudes and knowledge pertaining to HIV and AIDS. The sample used was 562 HCWs using an anonymous, voluntary questionnaire. Twenty-one percent of the respondents considered the provision of education by the employer as inadequate (Van Wissen & Siebers 1993).

Kitaura, Adachi, Kobayashi and Yamada, (1997), also carried out a study to determine the knowledge of a sample of 174 dental care workers. A self-administered questionnaire was used, and the items were based on AIDS educational matters, knowledge of transmission of HIV infection, risk factors and prevention methods. The findings were as follows; 80% had more than average knowledge; 9% claimed comprehensive knowledge and another 9% claimed that their

knowledge was poor. In conclusion, most of the respondents requested additional education. Their principal source of knowledge about AIDS had been acquired from the media such as television. The limited knowledge seemed to affect their attitude negatively.

Mbanya et al, (2001), in their study, used quantitative and qualitative research methods. This is one of the few studies where a qualitative approach was utilized. A self-administered questionnaire and focus group discussion were used to study the knowledge of health care providers in a rural setting. They found the lowest scores on knowledge were recorded in the 50-59 year age group and were no better in the attitude and the clinical practice section. The younger staff appeared to be more knowledgeable about HIV/AIDS than, the older ones. This was expected as the older members of staff were trained in the era before the HIV/AIDS pandemic. Thus, knowledge was significantly influenced by the grade of the staff.

2.10 Health workers' attitudes towards HIV/AIDS patients

According to Baron and Byrne (2000) attitudes are learned, evaluative concepts associated with the way people think, feel and behave. This means that attitudes have three components namely, the cognitive part, which is the idea, the affective part, which is the emotion that charges the idea and the behavioural part, which is the inclination to act. One of the concepts in the study of attitudes consists of a person's evaluation of the liking of, or emotional response towards some object or person. Usually one's attitude is not just a matter of opinion. One's attitude is regarded as a reality, at least until someone can introduce new facts or arguments to change a person's mind (Eiser & Pligt, 1988).

Although the risk of HIV infection from patients is low, staffs are still apprehensive if one considers the following facts. The incidence of needle stick injuries, according to the Centre for Disease Control (CDC) (1989), is 1 per 250 needle sticks involving HIV infected material. In spite of this low incidence, it is imperative that health care professionals develop a positive attitude towards taking care of their clients. An estimated 5,800 HCWs have AIDS in America and more are said to have the virus but have not yet developed AIDS (Wicher, 1993). It was reported by the CDC that 2586 HCW was reported in 1988 of having AIDS due to occupational

exposure (CDC, 1998). Although much has been done to study the characteristics and aetiology of the disease, the AIDS debate is continuing in trying to find other methods of transmission, and the best techniques for prevention (Wicher, 1993).

The attitudes of the general public towards people with HIV/AIDS are mostly negative (Okoli & King, 1993; Williams & Kennedy 1989). These people are stigmatized as being contagious with incurable diseases. As HIVAIDS, in particular, has generally been associated with groups of people such as commercial sex workers (prostitutes) and homosexuals who already carry a stigma (Wellings & Wadowath, 1990) including the fact that HIV/AIDS is a life threatening disease (Adebajo, Bangoda & Oyediran**,** 2003). Okoli and King (1993) expressed similar sentiments when they concluded that such negative attitudes were not only towards the disease or the virus itself, but also towards groups of people already affected and the means through which they get infected.

Another observation noted is that although most discussions on attitudes toward AIDS consistently focus on these negative feelings, an acknowledgement that such attitudes often cause harm to the infected, exists. People sometimes do exhibit positive attitudes. As these are normally expected reactions, they are overlooked, and studies have not been conducted to evaluate them. As Silver, Hopp and Rogers (1989) have pointed out that; negative attitudes towards HIV patients do exist, but health care professionals have a responsibility both to their professions and society. They argue that based on principals of natural justice all patients have a right to be treated. Unfortunately, despite the fact that the risk of infection by HCWs is low, (Chamberland, Conley, Bush, Ciesielski, Hammett, & Jaffe (1991); Kemppainen, Dubert & McWilliams (1996), HCWs still have the fear of contracting the infection, compounded with the fact that it is fatal, and the stigma associated with AIDS, often make it difficult to the HCWs to establish a therapeutic relationship with an AIDS client (Shearer & Davidhizar, 1999). It seems the anxiety related to HIV/AIDS may be due to the fear of possible contracting of the virus. In a study to determine who is more at risk of contracting HIV between non-health care workers and health care workers, the result revealed that HCWs were more at risk of being infected than non-HCWs, at the rate of 5.6% and 2.8% respectively. Knowing this, the anxiety they feel is to be expected.

Literature has shown that there are different views as to how much knowledge health workers have and what their attitude is towards HIV/AIDS patients. Attitudes held by health workers towards people with HIV/AIDS are usually negative, and this can affect the quality of care they render to HIV/AIDS sufferers. A number of studies have shown the negativity in the perception of people with the infection (Hodgson, 1997). This negativity could be due to lack of knowledge on HIV/AIDS, about its prevention and transmission. In a study of HCWs in Mexico, a sample of 204 HCWs and a 3 page self- administered questionnaire was used. The findings were that the majority were willing to care for these patients. This contradicts the following studies, which found nurses having a negative attitude towards treating HIV/AIDS patients. Hentegen, et al, (2002); Sherman, (1996); Kemppainen, St.Lawrence, Irizzary, Wiedema, Benne, Fredrick & Wilson (1992) surveyed how HIV/AIDS relates to attitudes and practise of HCWs. A self-administered questionnaire was used in all these studies, using a Likert scale.

The results were found to be as follows. They found 79% of the total sample believed that they were at risk of acquiring AIDS, mainly through occupational exposure. Negative attitudes were also noted; 20% of the workers thought the patients should be in quarantine. The results of this study showed clearly that nurses fear caring for HIV patients. The rest of the results indicated that the nurses had fear of contracting AIDS. What was not known was what influenced the nurses' attitudes. These results bring out the negativity of health workers to treating HIV positive patients. A study by Adebajo, et al, (2003), on knowledge, beliefs and attitudes of 254 health care workers in Nigeria, found that 55% of the workers felt that AIDS patients were responsible for their illness; 35.45% felt that the patients deserved the punishment for their sexual behaviours. Of the total, 18% felt that they would accept or encourage their children to visit an HIV positive individual. Two hundred and eight respondents were aware of the UPs for health workers while (26%) twenty six percent were aware that UPs existed at their workplaces.

A study conducted in Ghana on health care workers' attitudes towards HIV/AIDS confirms the existence of fear of infection due to working conditions such as the insufficient supply of basic protective items and inadequate information on the sero status of some patients (Awusabo-Asare, & Marfo, 1997). They used a purely qualitative method, utilized both in-depth interviews and focus group, with a sample of 80 health workers. The study was on the attitudes and management

of HIV/AIDS among health workers. It was observed that there was a gap between knowledge and practice among the workers. In addition, two crucial dimensions of attitudes regarding people with HIV/AIDS infections by some health care workers, is fear of treating them, sympathy towards them and the feeling of responsibility for the patients (Ezedinach, Ross, Meremiku, Essein, Edem, Ekure & Ita, 2002). In conclusion, enhancement in education can help to some extent in changing attitudes. However, knowing about universal precautions will go a long way in preventing transmission of HIV from the mother to the child during labour.

2.11 Conclusions

Optimal uptake and adherence to PMTCT is difficult for women whose partner are not supportive of their involvement. It is, therefore, necessary for all stakeholders in the control of HIV to employ changes that will enhance couples participation in antenatal care and prevention of mother to child transmission of HIV. Although, there are a number of barriers believed to prevent Male participation in antenatal care services and prevention mother to child transmission of HIV, the perception of women could also be a factor. Few studies have been conducted as regard the perspective of the women towards their partner accessing antenatal services with them. This may not be unconnected with the patriarchal nature of most African society. It is, therefore, imperative that the attitude of women towards their partners' involvement in antenatal care is taken into consideration.

Chapter 3: Methodology

3.1 Introduction

This chapter describes the methodology used in the study. It explains the rationale for study design chosen and describes the research setting. The population, the sampling method, data collection and analysis are described. In conclusion, the ethical considerations regarding the study are explained.

3.2 Research design

The research design is a set of guidelines and instructions to be followed in conducting the research (Babbie & Mouton, 2001). According to Christensen (1985:155) research design refers to the outline, plan, or strategy specifying the procedure to be used in seeking an answer to the research question. It specifies such things as how to collect and analyse data. This section attempts to outline the research design that the researcher employed in carrying out the study.

3.3 Sampling

In carrying out research, some authors have referred to sampling methodology as a destiny of the study (Tashakkori & Teddlie, 2003). The researcher was aware of the limitations caused by the use of purposive sampling methodology and sought to address these by encouraging participants to be open during the semi - structured interview and through the use of questionnaires.

A sampling strategy is usually employed as a control technique for variables and Curtis et al (Curtis et al., 2000 – in Christensen, suggested that a sampling strategy should be based on the following guidelines:

A sampling strategy should stem logically from the conceptual framework as well as from the research question being addressed by the study. In choosing the appropriate sampling strategy,

the researcher was guided by the question; will the sampling frame logically assist in the gathering of data?

The sample should be able to generate a thorough database on the occurrences under investigation. The selected sample should also at least allow the possibility of drawing clear inferences from the data, allowing for credible explanations. From a qualitative design perspective, these inferences are referred to as internal validity or the degree to which one can be confident that changes in the outcome variable (effect can be attributed to a preceding variable [cause] rather than to other potential causal factors). In this inquiry, the sampling choice and decision facilitated the elimination of other potential causal factors.

The sampling strategy must also be ethical. Meeting this requirement for this study included seeking informed consent regarding participation from the subjects and their parents and guardians; explaining the risks and benefits of the study to the participants, their right to withdraw from participation at any time and assurances that confidentiality was maintained.

Lastly, according to these guidelines, a sampling plan should be feasible. Will the researcher be able to access all of the data that will be necessary for the study? In ensuring that required data is collected within the scheduled time frames, the researcher posted consent forms to parents and guardians three weeks before the investigation and designed questionnaires and a focus group sequence to ensure that data would be successfully collected.

3.3.1 Sampling criteria

In conducting an investigative study, the researcher should be specific about the criteria that define the population of participants (Polit & Hungler, 1999). The researcher employed purposive selection in order to identify nursing mothers and pregnant women. For comparability and consistency, women were surveyed in the department of child and maternal health, Quthing district.

3.3.2 Sampling criteria for the women

Sampling criteria for women is through purposive sampling methodology. The researcher was guided by the research objectives in Chapter one to target 25 women who are older than 18. They are either pregnant women or nursing mothers who is living with HIV. The women were drawn from Quthing district attending ante – natal care services at maternal and child health department of Quthing government hospital. Purposive sampling was ideal for this study because it explores the attitude of women in the district.

3.3.3 Sampling criteria for staffs of maternal and child health

The researcher also conducted in – depth semi structured interviews with staffs of the maternal and child health of Quthing government hospital. As this study used a qualitative research method, a purposive sampling consisting of 10 staffs of MCH, who was willing to participate, were selected. According to Neuman (2000) purposive sampling occurs when one selects cases with a specific purpose in mind. Brink (1996) refers to this method as the judgement of the researcher to select subjects who are representative to the phenomenon and who are conversant with the issue in question.

These staffs were selected purposively by virtue of their working at the department of child and maternal health in Quthing district and their involvement in the prevention of mother to child transmission of HIV. This is to enable the researcher to get their perspective on the challenges related to the prevention of mother to child transmission of HIV.

3.4 Quantitative and Qualitative research

The study employed qualitative and quantitative data collection and analysis techniques through self-administered questionnaires to collect data from 25 participants from age 18 and above. This data was complemented with information from staffs of maternal and child health department. This was done through semi – structured interview. This interview format consists of two sections: open-ended questions focused on HIV/AIDS related knowledge and attitudes and questions relating to the source of information. All sessions were conducted in English and tape recorded as participants fully understands English.

The study combined qualitative and quantitative data collection methods to increase the scope of attempting to understand women's attitude to their partners' involvement in antenatal care and prevention of mother to child transmission of HIV. Quantitative research provided detailed information about women's attitude and belief regarding antenatal care, their beliefs and perception to men's attendance at the antenatal clinic, and their knowledge and use of HIV care. This data was complemented with reviewed literature to provide information from similar studies related to the research.

3.5 Data collection

Data collection methods employed for this study was in two categories namely questionnaire and semi-structured interview. These methods were employed to collect data from the women participants and the staffs of MCH respectively.

3.5.1 Questionnaire

The researcher designed questionnaire for 25 participants (all females) to elicit data from the participants including their attitudes and beliefs regarding antenatal care, beliefs about male participation in antenatal care, perception of men's attendance at the antenatal clinic, and their knowledge and use of HIV care. According to Numan (Numan, 1982 – in Kastande, 2009), the questionnaire enables the researcher to collect data in field locations where information can be quantified to elicit the responses needed for analysis. In this study, the questionnaire was administered to 25 women participants.

3.5.2 Semi-structured interviews

A semi – structured interview guide with open-ended questions, informed by existing literature on the subject, was used. The instruments comprised a section for obtaining demographic data such as age, years of service, and the level of education of the participants. For clarity of issues and further explanations on the issues being discussed, the researcher employs the use of probing technique as a means to elicit responses from the participants. The interviews were tape recorded, and it was conducted in English. Appointments were made with the interviewees at the

time that was convenient for them, setting, of their choice, and it lasted approximately 45 minutes.

3.6 Pilot study

A pilot study was conducted prior to the actual data collection using staff and community members. These groups of people were not part of the study. This was undertaken as a trial run to determine whether the questions were clear and the appropriateness of the questionnaire and the interview guide. Final modifications were made with the input of these focus groups. The semi-structured interview and questionnaire consisted of both closed and open-ended questions.

3.7 Reliability and validity

Bless and Higson-Smith (2000) states that reliability of the instrument is the degree of consistency with which it measures the attribute it is supposed to measure. On the other hand, validity, according to Silverman (2000), is the degree to which an account truthfully represents the social phenomena to which it refers. However, this is only useful in quantitative research. Since the reliability in qualitative methodology cannot be established as in a quantitative study, there has to be an alternative approach to measure the authenticity of a study such as credibility, transferability, dependability and conformity. (Baumgartner, Strong & Hensley, 2002; Marshal & Rossman, 1995).

3.7.1 Credibility

According to Marshall and Rossman (1995) one of the ways in which a researcher can have a credible study is to ensure that the research was done in such a way those participants were correctly identified and described accurately. In this study, the researcher has been able to identify ideal participants suitable for the study being undertaken and gave an accurate description of them. Also, the researcher identified the women as being pregnant or previously pregnant and is above 18 years. The researcher ensured that the tape recorder was in good working order prior to commencement of the semi-structured interviews. After each interview, the researcher listened to the quality of the recorded interview. This was to verify the

effectiveness of the recording. This was necessary in case the data is to be subjected to independent analysis. The procedures above were attempts at making the study credible.

3.7.2 Transferability

Marshall and Rossman (1995) refer to transferability as "how the research findings can be generalized or transferred from the representative sample to the population" the researcher is expected to provide sufficient descriptive data in other to allow others to be able to apply the results to other settings (Polit & Hugler, 1995). In this study, an accurate description of the research methodology and data analysis is ensured. It will also be supported by direct quotations from the interviews. This method constitutes "a thick description," which is a condition of transferability (Marshall & Rossman, 1995).

3.8 Data analysis

Miles and Huberman (1994) define data analysis "as three linked sub-processes: data reduction, data display and conclusion drawing verification" while Marshall & Rossman, (1995) describe it as the procedure categorizing, structuring and putting meaning to the data collected. Each questionnaire was analysed and discussed on the basis of the results. Similarly, interviews were listened to and the transcribed verbatim. The transcriptions were the compared to the audio tape - recordings to confirm the accuracy (Neuman, 2000). This was followed by verification and analysis of the data.

3.9 Ethical considerations of the study

Ethical issues were observed in all aspects of the research. Policy regarding confidentiality and anonymity with regard to matters related to HIV and AIDS has been considered in this study. Information collected from collected from subjects was not directly linked to individuals and participation in the study was voluntary and through informed consent. Participants were informed about the objectives of the study and the benefits to participants. Care was taken to ensure privacy and confidentiality of all the participants, due to the sensitivity of the information that was sought from respondents.

Chapter 4: Results

4.1 Introduction

The chapter endeavours to give meaning to the data by presenting it clearly and concisely. The analysis and interpretation of both the questionnaire and semi structured interview obtained through face to face interviews are discussed under themes and categories. The questionnaire was distributed to participants over the course of one week. The participants met eligibility criteria to participate. The participants are 18 years older, being current or previously pregnant and living with HIV. Interviews were also conducted for the staffs of maternal and child health, of Quthing government hospital. The interviews were conducted within a period of two weeks. A semi structured interview guide was used to collect data incorporating probing technique to elicit more reaction. The data from both the questionnaire and the interviews are based on the informants' personal experiences.

4.2 Analysis of data from questionnaire

4.2.1 Demographic characteristics of the women

A total of 25 women participated in the study. The average age was 30 years. The majority of the women finished grade 12, and only two of the women had post matric qualifications. All but two of the women had attended antenatal clinic during the previous pregnancy. All the women presently pregnant are enrolled in the antenatal clinic. The average age of non-pregnant women was 34.8 years compared to 29 .2 years in the pregnant women. The participants identified the following pregnancy outcomes: 22 (88%) had not had a pregnancy loss, and 3 (12%) identified at least one pregnancy. None had given birth to set of twins. None of the women had given birth prior to 1990, with none identifying their partner's involvement in the antenatal clinic. Out of all the women that participated, only 3 representing (12%) identified their partner's participation in their antenatal care services. This does not represent a significant statistics despite several initiatives to encourage male participation.

Table 1. Demographic and obstetric characteristics of women in Quthing district hospital who participated in survey of attitudes to antenatal care (N = 25)

Demographic and obstetric characteristics	**n (%)**
Age, y	
18 – 19	1 (4)
20 – 24	5 (20)
30 – 39	15 (60)
40 – 49	4 (16)
50 – 55	0
Educational level	
None	2 (12)
Grade 7 and below	5 (32)
Grade 8 – 12	6 (24)
Grade 12 and above	12 (48)
Occupation	
Farming	0 (-)
Health Care worker	1 (4)
Business	4 (16)
Domestic worker	1 (4)
Student	2 (8)
Housewife	5 (20)
Other	12 (48)
Religion	
Catholic	4 (16)
Anglican	5 (20)
L. E. C	11 (44)
Other	3 (12)

None/Traditional	2 (8)
Marital status	
Married	15 (60)
Single	5 (20)
Widowed	4 (16)
Divorced	1 (4)
Polygamous	0 (-)
Number of times pregnant	
Primigravida	3 (12)
Missed entry	1 (4)
1	9 (36)
2 – 4	12 (48)
5 and over	- (-)
Year of last birth	
Number Previous birth/Missed entry	1 (4)
1980 – 1989	- (-)
1990 – 1999	- (-)
2000 – 2005	- (-)
2006 – 2008	- (-)
2009 – 2013	24 (96)

4.2.2 Summary of data collected through questionnaire

4.2.2.1 Attitude and beliefs of women

Table 2 presents women's attitudes and beliefs regarding antenatal care. The findings revealed that the four primary reasons women come for antenatal care were to identify and treat health problems (96%) and to monitor foetal viability and growth (92%). Other reasons given are for them to have a good physique and healthy baby (80) and to increase their knowledge about their reproductive health and the type of diet they could take to sustain themselves and the child. Almost 88% of women identified liking the lectures (group health education and drama presentations given by staffs before the obstetric examinations begin) as the best part of clinic, with having a normal obstetric and foetal examination (80%) equally important. Majority of the women (76%) could not identify anything they did not like regarding antenatal care services in response to what they liked the least about antenatal clinic. Their chief complaint was the long wait (60%).

Table 2. Women's attitudes and beliefs regarding antenatal care. (N=25)

Women's antenatal care attitudes	**n (%)**
Women's reason for antenatal care attendance	
Health problems can be identified and can be treated	24 (96)
To help determine if the foetus is alive and growing well	23 (92)
To build up a good physique and healthy baby	20 (80)
To have more understanding on self and type of nutrition	17 (68)
Other	2 (8)
No reason given	1(4)
What do you like best about antenatal care?	
Good lectures	22 (88)
Good check-up	20 (80)
The staffs are kind and supportive	18 (72)

Clean environment	9 (36)
Other	5 (20)
Being with other pregnant women	3 (12)
Unable to identify anything good	1 (4)
What do you like least about antenatal care	
Unable to identify anything I don't like	19 (76)
Long wait	13 (52)
Other	9 (36)
Staffs are rude and not helpful	2 (8)
Dirty toilets	1 (4)
Men checking women	3 (12)
Did not wish to answer the question	- (-)

Note; Results do not sum up to 100% as multiple answers to these responses were allowed

4.2.2.2 Involvement of men in antenatal care

A series of questions was asked regarding men's involvement in antenatal care (Table 3). One of the questions asked was "whether it was okay for the male partner to accompany her partner to the antenatal clinic?" Almost 84% of women responded "yes," with only 8% of women responding "no". They were then asked to explain the rationale for their answers. The women answering "yes" pointed out couples counselling and testing of HIV (80%) and bolstering their partners' ability on matters relating to antenatal care (72%) made them said yes. The women responding "No" sighted work related as the reason why it is not appropriate for their partner to accompany them to the antenatal clinic. While two thirds of the women, not in support of their male partner coming to the clinic with them, sighted cultural factors and gender beliefs.

Those women whose partners had come to the clinic with them were asked how they perceive their partners' involvement. Their response ranges from being happy at their partner's participation, as this is a sign of true love to rendering support in case of difficulty. They claimed further that, it afforded the man the opportunity of knowing more about HIV and getting tested. The women were also asked how men in their villages commonly supported their partners. There

were varying answers given ranging from providing financial assistance to the provision of basic needs, offering to do the cooking and farming for the households.

When asked what do they think about their partner's support? Majority of them said, "Yes." It was enough. Those women responding "yes" were then asked the rationale for their response. Majority of them felt their partner cannot do more than that, and only a handful of them said it was on the recommendation of the staffs of the hospital. Those women answering "no" to this question felt a lot still needs to be done in terms of support during their gestation period. In response to what the women think can be done during their pregnancy, responses include provide me with nice food, help with house chores, show more love, give me more money, and visit clinic with me

Table 3. Women's beliefs about male participation in antenatal care. (N=25)

Responses to questions about Women's beliefs	**n (%)**
Is it good for a man to come to the antenatal clinic with his partner?	
Yes	17 (68)
No	7 (28)
Other	1 (4)
Did not wish to answer question	- (-)
Why is it good for a man to come to the antenatal clinic?	
Both can have HIV testing and know status together	20 (80)
To increase his knowledge of antenatal activities	19 (76)
In case of infection they can be treated together	18 (72)
It shows real love and faithfulness for each other	21 (84)
It makes her happy and feel she is supported	17 (68)
The man will benefit from first-hand information	15 (60)
Other	5 (20)
No reason	3 (12)
Did not wish to answer question	1 (4)

Why is it not good for a man to come to the antenatal clinic?	
Many men do not have time to come	6 (24)
Pregnancy is a woman's affair	5 (20)
It is not in our culture	5 (20)
Other	3 (12)
No reason	2 (8)
The woman may be ashamed and uncomfortable	3 (12)
His other wives will be jealous	- (-)
Did not wish to answer the question	- (-)
What do most women in your village think about men who come to the antenatal clinic?	
It is normal	19 (76)
It is not normal	8 (32)
The man is jealous and overprotective	11 (44)
It is an act of responsibility and true love	13 (52)
It is a sign of weakness in the man	6 (24)
Other	3 (12)
Did not wish to answer question	1 (4)

Note; Results do not sum up to 100% as multiple answers responses to these were allowed

4.2.2.3 Perception about men involvement in antenatal

Table 4. Women's perception of men's attendance at antenatal clinic. (N=25)

Responses to questions about men's attendance	**n (%)**
Has your partner ever come with you to the antenatal clinic?	
Yes	7 (28)
No	18 (72)
Have you ever asked your partner to come to the antenatal clinic?	

Yes	11 (44)
No	14 (60)
When you asked, did your partner accept? [a]	
Yes	6 (54.5)
No	5 (45.6)
If he did not accept, what did he say? [b]	
He did not have time	4 (80)
He said, "I do not have anything to do there"	3 (60)
He said, "It is not me who is pregnant"	1 (20)
He did not wish to answer me	2 (40)
Other	1(20)
Did not wish to answer question	1 (20)
Why have you never asked your partner to come to the antenatal clinic? [c]	
I know he will never accept to come	8 (57.1)
He does not have time	7 (50)
He is not always around	6 (42.8)
He does not have anything to do there	4 (28.6)
His presence will make me feel uncomfortable	2 (14.2)
Other	5 (35.7)
Did not wish to answer	1 (7.1)

[a] Number = 11

[b] Number = 5. Note: Results do not add up to 100% as multiple answers to these responses were allowed

[c] Number = 14 Note: Results do not add up to 100% as multiple answers to these responses were allowed

Table 4 presents the women's perception about men's antenatal care involvement. About 28% of the respondents claimed their partner had participated in their antenatal care. Majority of the women (60%) had never asked their partner to accompany them to the clinic on the assumption

that he will not come. Among those who asked, more than half claimed their partners had accepted representing 54.5%. The primary reason given why the man did not come was "he did not have time" (80%).

4.2.2.4 Knowledge and use of HIV

In addition, questions pertaining to HIV were asked (Table 5). Most of the women (92%) claimed they had heard about HIV, and all the women had undergone counselling and testing for HIV during the course of their pregnancy. Almost half of the women (48%) claimed their partner might have been tested for HIV at least once; however, 32% could not say whether their partner had been tested or not. 92% of the respondents had HIV counselling during their gestation period and were asked their thoughts on it; responses included being happy with counselling (60%) or not at ease with it (28%). Other responses included that the counselling was normal and scared of being HIV positive, were expressed by 12% of the women. The women claimed they had been given education on how to avoid getting infected with HIV and said the following; having one sexual partner and remaining faithful (92%), abstaining from sexual activity (88%), used only sterilized sharps (80%), use condoms (72%), and avoid risky places like drinking spots (16%). (Multiple responses accepted).

Table 5. Women's Knowledge and use of HIV care. (N=25)

Responses to questions about women's knowledge and use of HIV care	**N (%)**
Have you heard of HIV/AIDS?	
Yes	23 (92)
No	1 (4)
Missed entry	1 (4)
Have you had PMTCT counselling in antenatal	
Yes	23 (92)
No	1 (4)

Did not wish to answer question	1 (4)
Have you had an HIV test?	
Yes	24 (96)
No	1 (4)
When did you have the HIV test? [a]	
Only during pregnancy	20 (80)
Only when not pregnant	15 (60)
When pregnant and when not pregnant	23 (92)
Other	1 (4)
Did not wish to answer question	1 (4)
Has your partner ever had an HIV test?	
Yes	12 (48)
No	3 (12)
I do not know	8 (32)
Did not wish to answer question	1 (4)

Abbreviation: PMTCT, prevention of mother-to-child transmission

[a] Number = 25. Note: results do not sum up to 100% as multiple responses to these questions were permitted

4.3 Discussion

The purpose of this research was to identify women's attitudes and beliefs concerning HIV and their partners' involvement in antenatal care. The outcome of the study showed that the majority of the women (68%) would like their partner to participate, while only a handful of women (28%) were not supportive of their partners' involvement. This might not be unconnected with a recent change in social and cultural attitudes, with women identifying increasing number of men coming to the clinic compare to the times past. Most women are beginning to realize this is part of an option in their antenatal services care.

It is pertinent to say cultural changes and social interventions in deeply culturally enshrined communities are neither quick nor straight forward, and evolvement through time is required for it to be accepted by the communities. The outcome of the study reflects cultural and social attitudes in metamorphosis. Although most women were individually supportive of theirs partners' participation, some of the women identified community barriers as some of the factors hindering their participation. Nearly one - fourth of women established that their partners had come to the antenatal clinic with them, and less than half of the women had ever even invited their partners.

The researcher did not find negative attitudes and beliefs regarding antenatal care by the women. These women regarded antenatal care to be important towards their safe delivery. Majority of the women could not pin point any dissatisfaction about the way the clinic is run. This positive belief could be attributed to the way the pregnant or nursing mothers were treated in the clinic. The women associations of good clinical examination with a positive pregnancy results is expressed by their answers regarding their own antenatal care. About 4% of the women had experienced loss of pregnancy, with only two women had experienced child loss after birth. Therefore, the probability of a child surviving after birth is high. In Quthing district, the probability of a child surviving is bolstered by accessibility to the antenatal clinics; pregnant women staying far away are accommodated in the hospital, the presence and use of improved medical care.

Education has been linked to increase attendance of women accessing antenatal care services. Donkor E. S and Obed. S A. 2012 conducted a study on the waiting time and women's satisfaction at antenatal clinic in Ghana; found out that education has a positive role to play in increase attendance of the women in the antenatal clinic. The literacy rate of the women accessed by the researcher was very high (88%) as seen by over half having some secondary and higher education. Their level of education coupled with educational sensitization such as family health days in the district certainly contributes to the participant's accessing and their positive attitudes towards antenatal care.

In this study, the participants were happy with the antenatal care they received with 88% of the women expressing satisfaction about the group education sessions while over 70% identified the

kindness and support received from the staffs as what they like most. The women identified antenatal care as helping them to build a good body and the baby as one of the reasons for attending antenatal care services. This may be connected to the knowledge gained during the group teaching, as there is the focus on nutrition in pregnancy, with individual counselling made available if requested for. It is not impossible that their responses reflect the success of this education.

Majority of the women could not identify anything they don't like about their care although; their primary concern was that they had to wait for a long time at the clinic. The long wait has been identified as one of the hindrances to their partners' participation in antenatal care. Waiting for a long time have been shown to be the chief complaint of most African women (Lincetto O, Moathebesoane –Annoh S, Gornez P & Munjanja S. Opportunities for Africa's newborns; 2006:51-60). It has been argued that Women and their families incur substantial opportunity costs when ANC entails travelling and waiting for long hours. Tackling waiting time poses a challenge because of facility constraints (only one room available for examination) and inadequate staffs to conduct antenatal clinic sessions.

The repeated contacts between the pregnant women, nursing mothers and the staffs of the maternal and child health offers opportunities to encourage the staffs to find means to decrease the amount of time spend by clients waiting without eliminating any component of the antenatal care services. It is imperative to add that knowledge about community needs and behaviours as well as a direct link to the community via community health workers is critical, especially for strengthening the household to the hospital chain.

Lincetto O, Moathebesoane-Annoh S, Gornez P and Munjana S, 2012: found out those financial barriers impacts on the ability of the women to access antenatal care in some African countries. In Lesotho, Men control the finances of their families, which can impact negatively on the ability of the women to access antenatal care. The care received by the women often times is dependent on the financial capability of their male partners. Replacing user fees with alternative financing mechanisms should be seen as one of the steps towards improving access to antenatal care services.

In African context, the man's responsibility to take care of the obstetric costs of the women is viewed within the prism of marriage. In order words, the woman and her family will have to bear the costs of care when there is not committed relationship. In this study, over one-third of the women (40%) were single, widowed, or divorced.

In African studies, lack of effective communication has been linked to gender barriers. (Magoma M, Requejo J, Campbell O, Cousens S, and Filippi V: high ANC coverage and low skilled attendance in a rural Tanzanian district.2010; 0:13). Majority of the participants talked about love and emotional support from their partners. Over 80% expressed that men should show more love to the women when pregnant, and 68% of women are of the opinion that the presence of their partners' at antenatal clinic showed their concern and care. These highlights the women's wish for open communication with their partners'. Improving communications between partners can be achieved through community discussions, acceptance, and the realization that both men and women have a role to play in plugging the communication gaps.

HIV counselling and testing were considered to be an important component of antenatal care by the women. In Lesotho, HIV testing and counselling was integrated as a routine and expected part of antenatal activities in an effort to prevent transmission of HIV from the mother to the child. Antenatal clinic is one of the areas where women accessed HIV counselling and testing. Most women supported the idea of testing and counselling as part of antenatal care. The support given by women to counselling and testing also extends to couples counselling as expressed by 80% of the women in support of it been part of antenatal care. Despite the support showed by the women, gender barrier was evident in the women's responses to their partners' testing. Many women did not know whether their partner had undergone HIV test. It is pertinent to say that antenatal HIV counselling and testing are provided individually by the staffs of maternal and child health of the hospital. An important part of this counselling includes offering information on how to prevent HIV infection and PMTCT. This could be seen in the number of women (92%) that identified with counselling as one of the ways to avoid HIV infection.

4.4 Analysis of data collected through interviews

4.4.1 Introduction

One of the objectives of this chapter is to give meaning to the data by presenting it in such a way that it is clear and devoid of any controversy. The analysis and interpretation of the qualitative responses obtained through recorded face – to – face interviews are described under theme and categories. The interviews were conducted within a period of two weeks in November, 2013. A semi structured interviewed guide was used to collect data, with probing incorporated. This data is based on informants' personal experiences.

4.4.2 Demographic characteristics of participants

The participants consist of ten staffs of the maternal and child health of Quthing government hospital, Quthing, Lesotho. There were nine females and one male attending to the needs of clients coming for antenatal services and prevention of mother – to – child transmission of HIV. The ages of the participants ranged from twenty – two to thirty nine years. A minority of the participants had six years and more of working experience while majority had five years and less. The qualification of majority of the participants was at a diploma level. Two of the participants have a degree in nursing and psychology respectively. The demographic data are documented in table 6 below:

Table 6. Demographic characteristics of staffs of Quthing district hospital who participated in the survey (N = 10)

Demographic characteristics	**n (%)**
Age, y	
22 – 27	4 (40)
28 – 33	4 (40)
34 – 39	2 (20)
Gender	
Male	1 (10)

Female	9 (90)
Educational level	
Diploma in nursing and midwifery	5 (50)
Diploma in counselling	3 (30)
Bachelor of .science in nursing	1 (10)
Bachelor of psychology	1 (10)
Working experience in years	
1 – 5	6 (60)
6 – 10	3 (30)
11 and above	1 (10)

4.4.3 Summary of data from interviews

In this study, the researcher had some predetermined categories derived from literature, which informed the data collection. Data was analysed by thematic analysis (table 7). This is the identifying, coding and categorizing of the patterns in the primary data (Baumgartner et al, 2002).

Table 7. Summary of categories and themes

Categories	**Themes**
Knowledge	
	Methods of transmission
	Stages of infection
	Clinical signs and progression
	Risks and prevention of HIV

	Transmission in the work place
	PMTCT
	Treatments
MCH staffs self-assessment of knowledge	
	Areas lacking knowledge
Attitudes	
	Sorry/Pity
	Neutrality
	Respondent's fear and risk of infection
	Basic human rights
	Willingness to treat
	Attitude to male partners'
Source of information	
	Mass media
Recommendation and needs of the Staffs of MCH	

4.4.3 Knowledge

4.4.3.1 Methods of transmission of HIV/AIDS

All the participants were aware that the most common mode of transmission was through sexual activities. The participants mentioned this without hesitation. The other modes that were mentioned were sharing of unsterile needles and blades and blood transfusion. One of the informants said:

……of course sexually, that is one, then the use of needles. I mean if you are exchanging the use of needles, razor blades, and all with someone who is HIV positive……(3).

All the respondents were able to mention mother – to – child transmission, one of them said:
I know there are different transmissions modes of transmissions. One of the different modes of transmission is the transmission of HIV from the mother to the child. Others include unprotected sexual intercourse between man and a woman and also through people of the same sex (9)
…..as for children through breastfeeding as well as during labour, but the risk of the child contracting HIV during gestation is low (9).

The assessment of knowledge on hepatitis B was included because of similarities between hepatitis B and HIV in terms of transmission and prevention. It is important to emphasise that hepatitis B is a life threatening infection, yet it does not receive as much publicity as HIV/AIDS in the media. Some of the participants were ignorant about prevention and modes of contracting Hepatitis B in the workplace and this elicit some interesting answers:
I don't know what hepatitis B is (3)

Few of the participants displayed ignorance as to how they could protect themselves from the disease while others knew that the transmission methods for HIV are similar to hepatitis B transmission:
I am not really sure (8).
Frankly speaking, I don't know how I can do that. But I know that hepatitis is quite dangerous (7).

From the answers, it was clear that a few of the participants lacked knowledge in this area. It became clear that few of the participants did not know the prevention methods for HIV/AIDS and hepatitis are similar this became apparent during the course of the interview. However, majority of the participants were able to provide a satisfactory answer:
…..Methods are similar to avoiding AIDS, avoid body fluids, contacts with open wounds, and use gloves, essentially adhering to universal precautions… (1, 2, 4, 5, 6, 9, 10).

Few of the participants mentioned vaccination as one of the ways of prevention. This may not be unconnected to the fact that hepatitis is rare. This response was given after probing the participants:

….Other methods through which hepatitis B could be prevented is through vaccination… (2, 9 10).

4.4.3.2 Stages of infection

All the participants were aware of the stages of HIV/AIDS as outlined by the world health organization (WHO). Although, some of the participants had forgotten some of the symptoms that constitute each of these stages. They were aware that the infected patient initially shows no clinical sign of infections and later; they suffer from the various symptoms in each of these stages as the disease progressed. One of the participants said:

When someone contracted HIV, you have what is called the incubation period during which time the individual will have flu like symptoms. If untreated/managed, the virus continues to multiply damaging the immune system of the individual until it becomes full blown AIDS…. (10).

4.4.3.3 Risk and prevention of HIV transmission in the workplace

All the participants mentioned the wearing of gloves as a protective measure from contracting HIV/AIDS from a patient. They were aware of all the protective barrier used in the work place, but some of them hardly followed all the protective measures when seeing clients as (6) explained:

…..during examination, we should protect ourselves by wearing gloves and care has to be exercised that we do not allow needle pricks if given injection to clients. The other thing is to avoid body fluids from clients and any blood products. However, I forget to wear gloves times when seeing clients.

Protective clothing was mentioned without elaborating on what constitute protective clothing:

….wearing protective clothing when treating a patient irrespective of her status (9)

Some of the participants mentioned the wearing of a mask as a form of protection. One of the participants felt that it would be difficult to get infected if staffs observed protective measures when treating patients:

Although our work entails the use of needles, we should protect ourselves from needle pricks by carefully and prompt disposal of sharps (7)

4.4.3.4 Awareness of universal precautions

Most of the participants seemed to have heard about universal precautions; very few had no idea as to what they were. After an explanation from the researcher, they realized that they knew about it, but the terminology seemed unfamiliar. After an explanation they continued:

…usually you have to use protective clothing, and you need screening and all (2).

In treating clients coming for antenatal care services, I wear gloves and face mask and change gloves between clients… (3).

A few of the informants explained that they do not adhere to the practice of universal precaution at all time. This was due to the fact that there are so many clients to attend to. According to one informant:

…..there are usually many clients, so it's difficult…. (5).

4.4.3.5 Prevention of mother – to – child transmission

All the participants were well aware of what PMTCT stands for. According to them, they were actively involved in implementing the programmes to see that there is zero transmission of HIV from the mother to the child. As mentioned by most of the participants:

……mother to child transmission is when an HIV positive mother passes the virus to the child either during the course of her pregnancy, labour, delivery and through breastfeeding. In other to avoid this, the pregnant woman will take a regimen of ARVs to prevent the mother from transmitting HIV to the child…. (1, 2, 3, 5, 7, 9, 10).

The participants were unanimous that strategies need to be put in place to ensure the success of prevention of mother – to – child transmission. One of the participants opined that:

…..we must ensure that pregnant women are tested for HIV and if found positive, there should be timely access to effective antiretroviral therapy… (6).

Other participants were of the opinion that:

….we need to educate the public on the need to be HIV negative especially women of reproductive age and their partners through reproductive health and to scale up of prevention services. Some were of the opinion that HIV positive women should avoid unwanted pregnancies

by ensuring adequate provision of family planning, availability of counselling services…….(4,7,8, 9,).

The researcher probed the participants further on the challenges they faced in effective implementation of prevention of mother – to – child transmission. They are of the opinion that there are a number of challenges facing them. One of the issues raised was the women live far away from the clinics, and the roads are not easily accessible for them to come to for their antenatal services regularly. They stated further:

……most of our clients are poor making it difficult them to come regularly. One of the ways in which we have managed to overcome this is by providing accommodation for such pregnant women within the premises of the hospital…. (1, 7, 9, 10).

In response to the question whether it is a good idea for a male partner's to access antenatal services with their pregnant women, all the participants welcomed the idea. They are of the opinion that it will make the implantation of the programme successful as this will encourage pregnant women to take their medication regularly and as at when due. Some of the participants have seen cases when pregnant women are afraid to take their medication because of their partner. In recounting their experiences:

…..some pregnant women expressed worry that their partners' might know they are HIV positive if they see them taken these medications. It will be very good to their male partners' accessing antenatal care services with them… (1, 4, 8).

Others opined that having both partners coming for the services is will ensure that both of them are counsel and tested.

….it will be beneficial to both partners' as both of them can know their status and support each other during the course of the Women's' pregnancy and in ensuring adherence to the antiretroviral drugs…. (2, 5, 7, 10).

The participants were of the opinion that it will be beneficial for pregnant women to have access to quality lifesaving HIV care that includes prevention and treatment services in response to a probing question on the way forward. The said a lot still needs to be done to ensure that the male

partners' of the pregnant women comes to the clinic with them. They opined that barriers to PMTCT need to be overcome, be it cultural, practical or social.

4.5 Treatment

4.5.1 Anti – retroviral drugs

All the participants knew the various types of anti-retroviral medication that are used in the prevention of mother to child transmission. They were able to highlight the various options used in PMTCT. Some of them went further on the integration of PMTCT and ART known as option B^+. The following statements reflect some of the participant's knowledge:

.....the option B^+ is a simplified approach in which pregnant women are given anti-viral so as to prevent the mother transmitting infection to the child…. (5, 6, 8).

Other participants opined that:

.....it is a basic approach to treating all pregnant women living with HIV. The women are given TDF, efavirenz, and 3TC as soon as they are diagnosed, and this will be continued for life. The children born of HIV positive mothers will be given a daily dose of NVP from bath through the age of 6 weeks. Thereafter, they will be given co-trimoxazole….. (1, 2, 7, 9).

4.5.2 ARV side effects

All the participants were able to identify one complications or the other of the antiretroviral medication. Some of the participants claimed, the side effects of the medication ranges from:

.....side effects of the antiretroviral medication range from constipation, rash, and diarrhoea…. (5, 6, 7).

....the side effect of this medication could also be hepatic toxicity, elevation of liver function tests, and change in taste buds sensation. Though I am yet to see any of my clients experiencing these side effects…. (2).

Judging from the participant's response, all of them were well aware of the side effects of these medications and what measures to take when any of their clients presents with any.

……some of the participants mentioned are headache, fatigue, hyperpigmentation of the nails and skin, and myalgia (1, 4, 8, and 9) while few of them mentioned mood changes, abnormal dreams, hyperlipidaemia, and confusion…. (1, 10). Clients are monitored throughout the course of their pregnancy and during breastfeeding. Liver function tests are done regularly to monitor the clients, and they are advised to report any untoward effects of the medications….. (3, 5, 7, 9, 10).

4.6 Self-assessment of knowledge

The study participants were questioned to rate their level of knowledge of HIV/AIDS. Most of the participants admitted having very good knowledge of prevention of mother to child transmission of HIV and other areas related to the infection. There was a general feeling that the knowledge they had was adequate even some of them expressed interest in enhancing their knowledge:

…my knowledge is adequate but will like to improve it further… (1).

The level of knowledge could be attributed to in-service training provided for the staffs of the department as revealed by some of them:

….We attends workshops regularly, and this has really helped me in enhancing my knowledge…. (2).

Absolutely, I think the in-service training had helped a lot…. (6).

I attended workshops on integrated PMTCT and family planning, so I am well equipped to provide service to clients…(8).

4.6.1 Attitudes towards HIV/AIDS patients

A variety of attitudes was detected in the participants' responses. Their feeling towards the pregnant or nursing mothers living with HIV ranged from feeling bad, sorry or empathetic to neutrality.

4.6.1.1 Sorry/Pity

…Sometimes you feel sorry for them, sometimes you empathize with them… (9).

Their facial expressions and tone of voice was an indication of their feelings:

….pity for others, it is like they never asked for it; they are like victims of circumstances… (5).

…I feel bad for the children especially during DNA-PCR investigation during which blood have to be taken from them… (2).

4.6.1.2 Neutrality

However, most of the participants said they had no specific feelings towards pregnant women or nursing mothers living with HIV/AIDS as they regard them as any other clients coming to the clinic for services:

… I don't have any ill feelings… they are patients, and it's just like any other diseases and you cannot blame them… (7)

…. I feel they are people like us, and there is nothing wrong with them. It is just that they have a condition that needs to be managed through medication…. (1).

…. I feel it is an unfortunate position to be in, and they should be treated with dignity… (10).

Some of the responses on how they felt about HIV/AIDS patients who contracted the infection through unprotected sex were:

… I feel sorry… (2)

… I think it is not completely their own fault, as some are vulnerable… (6).

4.7 Respondent's fear and risk of infection

4.7.1 Risk of infection

The participants were asked to give their opinion on their treating of pregnant women and nursing mothers living with HIV. Overall, the staffs of maternal and child health did not feel that they were at risk as protective measures have been put in place:

…we are not at risk because we are supposed to wear gloves… (1)

According to other participants:

…..we are not at risk because universal precautions should be followed at all times when treating clients…. (5)

4.7.2 Basic human right

It was evident from the answers given that, the participants acknowledged that their clients living with HIV were entitled to the same care as any other clients, since medical is a human right:

…they need care just like any other clients…they need to be counselled, encouraged and be monitored… (2).

…it is their right to be attended to and be treated… (6)

….as far as I am concerned, they are clients that needs services…. (10)

4.7.3 Willingness to treat

The participants were asked how they feel treating people living with HIV/AIDS on a regular basis. They replied, it their responsibility as health care practitioner to treat clients irrespective of their status. They felt that they had a moral responsibility to help the clients and that they were duty bound to provide service. They opined:

... I am here to attend to clients irrespective of their status… (2).

… I am just doing my job… (7).

... I would not be affected at all… (5)

In addition, the participants mentioned that they didn't have a problem concerning treating these clients. These perceptions are elucidated in the following quotations:

…treat them as other clients... (1)

… I harbour no ill feelings towards them; therefore, I don't have a problem offering them services… (4).

4.7.4 Attitude to male partners

The participants were unanimous that, male partners' accessing antenatal care services with their female partners' can play important role in improving adherence to ART and retention in ART:

…this will go a long way in helping the women to adhere to their medication and comes to terms with their condition….. (2).

…Male participation in antenatal care of their partner is low, and it will be nice if they can come to support their partners'… (5).

One of the participants responded*:*

….that it will provide a great opportunity for ART and PMTCT programs as this will reinforce client's adherence and retention… (9).

… We look forward to the day when male partners' will accompany their female counterparts in seeking care during the course of their pregnancy… (3).

4.8 Source of information

The participants obtained their in information on HIV/AIDS through attending workshops, media, namely radio, newspaper and television:

… I attend workshops regularly on PMTCT…. (7).

….. And the radio… (3).

…. I read from the newspaper, magazines and also from workshops….. (1)

… We attend workshops, seminars, and mortality review. That is how I get my information… (4)

However, none of the participants got their information from the library since the hospital do not have this facility:

…we have none. I don't think administration thinks it's important… (6)

…. The board room has some books but not HIV/AIDS… (10)

4.8.1 Needs and recommendations

4.8.1.1 Inclusion of HIV/AIDS in the curriculum

Many different concerns were expressed during the discussions. Few of the participants felt HIV/AIDS should be introduced in the curriculum:

…HIV/AIDS management has been introduced at postgraduate level; it will be good if the ministry can sponsor some of us…. (1).

…there should be regular CME module to update the staffs knowledge and clinical skill… (8).

…because of the seriousness of the issue, it will be nice to have HIV slide library… (4).

4.9 Discussion

In this study, the result of the interview is discussed in relation to its purpose while incorporating relevant literature. The study seeks to explore the perspective of the staffs of maternal and child health of Quthing hospital to male partners' coming with their female partners to access antenatal care services and prevention of mother to child transmission of HIV. The study also explored their knowledge and attitudes concerning clients in their care to live with HIV, as well as their perceived risk and fear of transmission in the workplace.

Nearly all the participants were able to identify the various mode of transmission including sexual intercourse. Over 70% of transmission occurred through heterosexual intercourse as sighted in some literatures. Other modes of transmission mentioned by the participants were sharing of needles among drug users, blood transfusion. They also mentioned that, the virus could be transmitted from the mother to the child during labour, breastfeeding, and childbirth. The participants' knowledge of the mode of transmission was quite good in this study.

The comparisons of knowledge on the transmissions of HIV and hepatitis B in this study showed that participants were more knowledgeable with the transmission of HIV than with hepatitis B. this could be as a result of the fact that it is not as common as HIV, and it has not been given wider prominence like HIV. These findings are consistent with the findings of Knights & Bodsworth, (1998). It is no gain saying that, prevention of Hepatitis in the workplace should be approached with the same seriousness as HIV transmission. It is imperative that medical practitioners should know the pathophysiology of HIV and AIDS. This is essential as it will help the staffs to be well equipped when educating the pregnant women and nursing mothers.

Most of the participants were aware of the stages and progression of HIV following infection. The stages were easily mentioned, but some could not remember the symptoms that constitute these stages. All the participants were aware that, in the later stages of infection, the patient will exhibit HIV/AIDS related symptoms. As part of the complication frequently encountered in the department is unexplained weight loss, pulmonary TB, persistent oral candidiasis, and neurological complications. According to O' Dell and Sasson, (1992) it has been reported that

people living with HIV can suffer neurological complications which significantly increased risk cerebrovascular disease. This complication has been attributed to a specific class of retroviruses named Lentivirdae (O'Dell & Dillon, 1992).

The term universal precaution was familiar to the participants though it had to be elicited from some of them. It is not fully observed either because of the limited resources or stock outs and either possibly due to lack of departmental continuous development (CPD), which would assist the participants in keeping abreast with the latest developments. Nevertheless, they were aware of how health professionals should protect themselves against infections including HIV in the workplace. Universal precautions are not followed at all times, but gloves are worn when seeing patients and there is adequate provision for the disposal of sharps. Most of the staffs do not wear protective clothing except their uniform. This may be due to the fact that it is inadequate or non – existent. This might not be unconnected with limited resources at the disposal of the hospital. These findings are consistent with the findings by Awusabo-Asare & Marfo (1997).

Most of the participants were aware that PMTCT serves as an entry point for the prevention of HIV and continuous follow up and care of HIV infected women, exposed infants. The participants were aware that the mother to child transmission (MTCT) of HIV is a major problem in Quthing district. Mother to child transmission (MTCT) of HIV is by far the main source of HIV infection in children. 'UNAIDS estimates that more than 90% of children acquire HIV through MTCT during pregnancy, labour, delivery and breastfeeding'. They were aware that MTCT may occur during pregnancy, labour and delivery, or breastfeeding with the largest number occurring during labour and delivery. The staffs knew it involved a comprehensive approach consisting of four components that must be complimented in order to optimize the effectiveness of the programme. The comprehensive approach includes primary prevention of HIV infection, prevention of unintended pregnancies among women infected with HIV, prevention of HIV transmission from women infected with HIV to their infants, and provision of treatment, care and support to women infected with HIV, their infants and their partners.

All the participants were of the opinion that in order to effectively provide PMTCT services, client's partners' should be equally involved and participate actively in the treatment while

rendering the necessary support for such family. It has been argued that stress and lack of supports have been linked to the progression of HIV infection. In order to prevent this, the participants were unanimous in their believe that pregnant women, nursing mothers and their partners should be encouraged and supported, offering counselling, HIV care and treatment where necessary.

4.9.1 Treatment

All the participants knew about the available ARV drugs and the combinations in which they are administered. The participants were aware that PMTCT is one of the vital components of the package of services offered to mothers. They opined that HIV infected mothers require special care during pregnancy and breastfeeding to ensure optimum health benefits to the mother and the baby as well as to reduce the risk of transmission of HIV to the infant. The staffs were well aware of the services at the disposal of the pregnant women viz a viz counselling for them and their partners, clinical and immunological staging, basic investigations and monitoring, prescription of ARVs for prophylaxis or treatment.

The participants were aware that all HIV pregnant women should receive integrated antenatal care services; they may require more than four visits as it is usually the norm. The participants were fully aware that a new guideline known as option B^+ has recently been introduced where pregnant women irrespective of their CD4 count were provided with ART. The participants were aware of the side effects these medications may cause, but some of them are not fully equipped to handle it.

In this interview, it was evident that the participants acquire acquired information through provision of handbooks and educational pamphlets and posters from the health ministry, workshops, seminars, mass media and magazines. This information is very detailed in most cases. Studies by Horseman and Sheeran, (1995); Mitchell (1999) found mass media to be an important source of information. According to Puckree, Kasiram, Moodley, Singh and Lin (2002), lack of knowledge is a source of concern at professional level. Every effort must be made to ensure that health professionals are well educated. Participants reported that there were no

functioning libraries though most of them acquire their knowledge through workshop and print from the ministry of health.

Regarding self-assessment of knowledge on HIV/AIDS, most of the participants rated their knowledge adequate. This was attributed to the workshop, and educational prints received even though some of them felt a lot still need to be done. Medical professionals need to be well equipped to handle pregnant women and nursing mothers together with their partners'. This is because the staffs of maternal and child health have an added role as educators to their clients and also as caregivers.

Majority of the participants in this study appeared to have empathy and a positive attitude towards HIV/AIDS. There was no ill feeling towards their clients. The participant's positive attitude towards their clients could be attributed to the fact that they were already treating HIV/AIDS patients, and it may have influenced them over time. Valimaki (1998) found attitudes to be shaped by experiences. The more positive attitude has been associated with the participants' direct experiences of knowing or caring for people living with HIV/AIDS. This finding was supported by study from All and Fried (1996).

The participants felt they were not at risk of contracting HIV since they were well aware of how to protect themselves from contracting HIV. The participants were aware of the causes and transmission routes of HIV. Thus it limits the fear of being infected. The participants expressed equally that their clients deserved to be treated equally irrespective of their status. This is in agreement with a study by Atchison (1990) who advocated that people living with HIV needs more care because of their special needs. The need to treat HIV positive mothers is not debatable, because every human being has a right to health irrespective of their condition. To help in their tasks, the staffs should adhere to the ethics of universal precautions when working in an environment that put them at risk.

Chapter 5: Conclusions and recommendations

5.1 Conclusion

What came out clearly in this study is that women have a positive attitude towards antenatal care and are in support of their partners' involvement in same. The staffs of maternal and child health of Quthing district hospital are also favourably dispose towards male involvement in their partner antenatal care services. It is widely established fact that pregnancy and antenatal care have in the past being seen as the traditional duty of the females, but with increase access to information, education, knowledge and awareness, and encouragement this stereotypical attitude is changing. Although the women were of the opinion that the male should be actively involved in their antenatal care, many believed that cultural factors are a hindrance.

Majority of the women identified gender barriers as hindrance to effective communication. Despite the fact that, 68% of women are in support of their partners' accessing antenatal care services, the number of those that actually invited their partner is less than 45% . Over 90% of the women had HIV counselling and testing, though it is disconcerting that 32% of them did not know whether their partner had tested or not. The research demonstrates that PMTCT had a positive impact on the women and the staffs of maternal and child health in providing HIV counselling and testing. Some of these women use antenatal clinic as the primary access to getting tested; therefore, it is essential that no efforts should be spared in provision of acceptable, quality care, and integrated antenatal and PMTCT care.

In this study, the staffs demonstrated sufficient knowledge about HIV/AIDS. This was also expressed in their self-assessment knowledge. Though they exhibited limited knowledge on the pathophysiology of the disease, it is imperative to understand and be knowledgeable about ART. This is due to the complications that may arise from given such medications. The staffs also exhibited a positive attitude towards their clients and showed a willingness to care for their clients irrespective of their status. This positive attitude could be due to the fact the participants have been treating people living with HIV for a long time. The knowledge acquired from

attending workshops, educational materials probably stood the workers in good stead so as to be able to offer integrated PMTCT and antenatal care.

From the study, it could be inferred that the amount of knowledge these participants possessed though insufficient in certain aspects, did not have a negative influence on their attitudes. Attitudes can be formed or are inherent in personal characteristics of the individual. It is possible for an individual to have adequate knowledge of HIV but still exhibit a negative attitude towards people living with HIV.

5.2 Recommendations

The level of male participation in PMTCT programme in Quthing district is low. This could be attributed to a number of factors such as an unfriendly environment, clinics designed for women and socio-economic factors. On this basis, I will like to make the following recommendations:

- Improvements in the health care system and community mobilization of men as regards the advantages of antenatal care and the PMTCT programmes are important for alleviating the effect of socio-economic and cultural factors.

- Efforts to promote male participation in antenatal care and PMTCT programme should continue through additional options made available to men to increase their participation such as creating a client friendly environment for the male partners.

- There is a need for departmental and institutional policy on the implementation of CPDs to continuously upgrade the knowledge of all health personnel on HIV and AIDS. This should be facilitated by the ministry of health, the hospital management in conjunction with non-governmental organizations (NGOs).
- There is a need to set hospital library and departmental library in the hospitals equipped with the latest journals, manuals or literature on recent developments on HIV and AIDS. The libraries should be continuously updated with recent trends and breakthrough on HIV and AIDS.

5.3 Areas for further research

The research identified the following areas that need further research:

- The research should be carried out on a larger scale using both quantitative and qualitative research methods. Further research on this study covering all the antenatal clinics in the country is, therefore, suggested.

- There is a need to investigate more, "the barriers to involvement of male partners' in the prevention of mother-to-child transmission of HIV programme in Lesotho".

- Further research on the attitude and knowledge of health care workers should be done on a wider scale. This may include increasing the number of participants and having focus groups discussion. This may cover all the health centres in the district, and it will involve both qualitative and quantitative analysis of the results.

5.4 Limitations of the study

The traditional and cultural barriers pointed out by the research participants most likely reflect what obtains in other part of the country. But, these socio-cultural factors and perception may be more common in rural rather than urban communities. This community would probably be considered a rural community; it will be interesting to know whether similar results will be obtained in the urban communities of the country.

The outcome of the study may not be representative of the wider Lesotho community because the women surveyed are from the same district. Finally, the research attempts to focus on antenatal care, and it cannot be taken for granted that these attitudes covered child birth. There has been recent studies indicating that men's involvement in antenatal care is acceptable and but participation in labour and birth is not. The sample size for both participants is small, therefore, cannot be generalized to the whole population.

Bibliography

Aarnio P, Olsson P, Chimbiri A, Kulmala T. (2009). Male involvement in antenatal HIV Counselling and Testing: exploring men's perceptions in rural Malawi. *AIDS care,* 21*(12):1537-1546*

Adebajo, S.B., Bangoda, O.A. & Oyediran, M.A. (2003). Attitudes of health care workers to people living with HIV/AIDS in Lagos State Nigeria. *African Journal of Reproductive Health.* 7(1): 103-112.

Aluisio A, Richardson BA, Bosire R, John-stewart G, Mbori-Ngacha D, Farquahr C. (2011). Male antenatal attendance and HIV testing associated with decreased infant HIV infection and increased HIV free survival. *Journal Acquire Immune Deficiency Syndrome,* 56*(1):76-82*

Awusabo-Asare, K. A. & Marfo, C. (1997). Attitude to management of HIV/AIDS among health workers in Ghana. The case of Cape Coast Municipality. *Health Transition Review*. *Supplement to volume.* **7:** 271-280.

Badran, G. I. (1995). Knowledge, attitude and practice the three pillars of excellence and wisdom: a place in the medical profession. **1:**8-16 [ONLINE] Available. www.emro.who.int/Publications/EMHJ/0101/01.htm [16/11/13: 19:20].

Bajuirrwe F, Muzoora M. Barriers to the implementation of programmes for the prevention of mother-to-child transmission of HIV: a cross sectional survey in rural and urban Uganda. *AIDS Res Ther* 2005 ;(2)10

Baron, A.C. & Byrne, D. (2000). *Social Psychology*. Boston. Allyn and Bacon. Buskin, S.E., Lin, L., Houyuan, Y., Tianj, Y. & McGough, J. M. (2002*).* HIV/AIDS knowledge and attitudes in Chinese medical professionals and students before and after an informal lecture on HIV/AIDS. *Journal of Public Health Management Practice*. 8(6): 38-43.

Baiden F, Remes P, Baiden R, Williams J, Hodgson A, Boelaert M, Buve A. (2005). Voluntary counselling and HIV testing for pregnant women in the Kassena - Nankana district of northern Ghana: Are couple counselling the way forward*? AIDS Care*, 17*(5):648-657.*

Benkele RG. Male involvement and participation in prevention of mother to child transmission (PMTCT) of HIV/AIDS: the case of Chipata district. *In Bachelors University of Zambia, Department of Nursing*; 2007.

Byamugisha R, Tumwine J, Semiyaga N, Tylleskar T. (2010). Determinants of male involvement in the prevention of mother to child transmission of HIV programme in Eastern Uganda: a cross sectional survey. *Journal of reproductive health* 7(12) retrieved April 13, 2013 from http://www.ncbi.nlm.nih.gov/pubmed/20573250

Byomire H. Prevalence and factors associated with male involvement in the prevention of mother to child transmission of HIV in Mulago Hospital. *In Msc Thesis Makerere University, Department of Medicine (Clinical Epidemiology Unit);* 2003

Caldron, R. (2001). *The HIV/AIDS Multidimensional Model*. Arlington. AIDSCAP

Center for Disease Control. (1989). Guidelines for prevention of transmission of human immunodeficiency virus and hepatitis B virus to health care and public safety workers. *Morbidity and mortality weekly reports.* **38(s6):** 1-36.

Centers for Disease Control and Prevention. *Couples HIV Counselling and Testing Intervention and Training Curriculum.* Atlanta, Georgia: CDC; 2007

Chamberland, M.E., Conley, L.J., Bush, T.J., Ciesielski, C.A. Hammett, T.A. & Jaffe, H.W. (1991). Health care workers with AIDS, national surveillance update. *Journal of the American Medical Association.* **266(24):** 3459-62.

Chirwa E, Noor K, Malata A, Mambulasa J. A community participatory process for peer group HIV prevention. *Afr j midwifery womens Health.* 2011; 5(3):111-116

Ditekemena J, Matendo R, Koole O, Colebunders R, Kashamuka M, Tshefu A, Kilese N, Nanlele D, Ryder R. (2011). Male Partner Voluntary Counselling and Testing Associated with Antenatal Services in Kinshasa, Democratic Republic of Congo: a randomized trial. *Int J STD AIDS,* 22*(3):165-170.*

Donkor ES, Obed SA. Waiting time and women's satisfaction at antenatal clinic in Ghana. *African journal of midwifery womens Health*. 2012; 6(1):7-14

Eiser, R.J & Van der Pligt, J. (1988). *Attitudes and Decisions*. London. Routledge.

Ezedinachi, E.N., Ross, M.W., Meremiku, M., Essien, E. J., Edem, C. B., Ekure, E. & Ita, O. (2002). Impact of an intervention to change health workers' HIV/AIDS attitudes and knowledge in Nigeria. *Public Health.* **116:** 106-12.

Gatsi, T. L, Amosun, S.L. & Mhlanga, F.G. (1994). Rehabilitation personnel and AIDS in Zimbabwe: Knowledge, attitudes and professional behaviour. *Physiotherapy Theory and Practice.* **10:** 95-102.

Gender, Sexuality, and HIV/AIDS (May 2002) http://www.popcouncil.org/pdfs/horizons/rs/Re_gender_hiv.pdf Accessed October 20, 2013.

Hodgson, I. (1997). Attitudes towards people with HIV/AIDS: Entropy and health care ethics: *Journal of Advanced Nursing.* **26(2):** 283-288.

Jasseron C, Mandelbrot L, Dolfus C, Trocme N, Tubiana R, Teglas JP, Faye A, Rouzioux C, Blanche S, Warszawski J. (2011). Non – Disclosure of pregnant woman's HIV Status to Her Partner is Associated with Non – Optimal Prevention of Mother-to-Child Transmission. Journal AIDS and Behaviour, 10. Dol: 10.1007/s10461-011-0084-y

Joint United Nations Programme on HIV/AIDS. Global report: UNAIDS report on the global AIDS epidemic 2010: *www.unaids.org/global report/Global...report.htm*. *2*010. Accessed April, 19 2013.

Kemppainen, J., ST. Lawrence., Irizzary, A., Wiedema, D., Benne, C., Fredrick, C. & Wilson M. (1992). Nurses' willingness to perform AIDS patient care. *Journal of Continuity Education in Nursing.* **23(3):** 111-116.

Kiarie JN, Farquhar C, Richardson BA, Kabura MN, John FN, Nduati RW, John – Stewart GC. (2006). Domestic violence and prevention of mother – to – child transmission of HIV -1. *AIDS,* 20*(13): 1763-1769*

Kitaura, H., Adachi, N., Kobayashi, K. & Yamada, T. (1997). Knowledge and Attitude of Japanese dental health care workers towards HIV related disease. *Journal of Dentistry.* **25:** 279-283.

Koning, de K. & J. Kemp. (1998). The concept of 'high risk groups'. In: Research for Sex work **1:** 1-2. [ONLINE]. Available: file://A: The %20concept%20of%20`high%20risk20groups`. htm [19/11/2013:20.00].

Kizito D, Woodburn PW, Kesande B, Ameke K, Nabulime J, Muwanga M, Grosskurth H, Elliot AM. (2008). Uptake of HIV and syphilis testing of pregnant women their male partners in a programme for prevention of mother to child HIV transmission in Uganda. *Tropical Medicine International Health,* 13(5*):680-682*

Lambert, M. (1989). The individual therapist's contribution to psychotherapy process and outcome. *Clinical Psychology Review.* **9:** 469 –486.

Lincetto O, Moathebesoane-Anoh S, Gornez P, Munjanja S. Antenatal care. Chapter 2. In: *Opportunities for Africa's Newborns*. Geneva, Switzerland: Partnership for Maternal, Newborn & Child Health (PM-NCH); 20006:51-60

Mann, J. & Tarantola, D. (1996). *AIDS in the World II.* New York. Oxford Press.

Mbizvo MT, Bassett MT. Reproductive health and AIDS prevention in Sub-Saharan Africa: the case of increased male participation. *Health policy plan* 1996, 11:84-92.

Mlay R, Lugina H, and Becker S. (2008). Couple counselling and testing for HIV at antenatal clinics: views from men, women and counsellors. *Journal of AIDS Care*, 20*(3):356-360* retrieved April 13, 2013 from http://www.ncbi.nlm.nih.gov

Mohlala BK, Boily MC, Gregson S. (2011). The forgotten half of the equation randomized control trial of male invitation to attend couple voluntary counselling and testing. *AIDS, 25(12):1535-1541*

Msuya SE, Mbizvo EM, Hussain A, Uriyo J, Sam NE, Stray – Pedersen B. (2008). Low male partner participation in antenatal HIV counselling and testing in northern Tanzania: implications for preventive programs. *AIDS Care,* 20*(6):700- 709*

Mungherera, M., Van der Straten, A., Hall, T.L., Faigeles. B., Fowler, G. & Mandel, J.S. (1997). HIV/AIDS Related attitudes and practices of hospital based health workers in Kampala, Uganda. AIDS. *AIDS Supplement.* 1, S79-85.

Ndikom CM. Pattern of uptake of maternal health services in a rural community in Nigeria. *Afr j* midwifery womens Health. 2010; 4 (3):139-145

Nkuoh GN, Meyer DJ, Tih PM, Nkfusai J. (2010). Barriers to Men's Participation in Antenatal and Prevention of Mother to Child Transmission Care in Cameroon, *Africa. Journal of Midwifery women's Health, 55(*4*); 363 –369*

Okoli, O. & King, D. (1993). Attitudes towards people with HIV/AIDS. *Physiotherapy*. **79(3):** 168-173.

Peltzer K, Jones D, and Weiss SM, Shikwane E. (2011). Promoting male involvement to improve PMTCT uptake and reduce antenatal HIV infection: a cluster randomized control trial protocol. *BMC pub health 2011*, 11*:778*

Pilyugina, S., Katzenstein, D., Bergen, M., Usichenko, N. & Shapiro, J. (2000). HIV –related knowledge, attitudes and practices of Health care workers in Odessa, Ukraine. 13th International AIDS Conference Durban, South Africa. July 9-14.

Polit, D. F. & Hungler, P. (1999). *Nursing Research: Principles and methods*. Philadelhia. Lippincott Company.

Sauerborn R, Noutgtara A, Latimer E. (1994). The elasticity of the demand for health care in Burkina Faso: differences across age and income groups, *Health and Policy Planning. 1994*, 9*(2) 185-192*

Semrau K, Kuhn L, Vwalika C, Kasonde P, Sinkala M, Kankasa C, Shutes E, Aldrovandi G, Thea DM. (2005). Women in couple antenatal HIV counselling and testing are not more likely to report adverse social events. *AIDS,* 19(6*):603-609.*

Shearer, R. & Davidhizar, R.E. (1999). What every health care professional should know about AIDS. *Health Care Manager*. **18(1):** 53-64.

Silver, M. Hopp, J. W., & Rogers, E.A. (1989). AIDS and the Allied professions. FA Davis Philadelphia. *Journal of Applied Philosophy*. **6(2):** 119-153.

Soon, C.W. & Barnard, A. (2002). A phenomenographic approach to examine the different ways HIV patients understand the experience of counseling. *Journal of Mental Health.* **1(2):** 14.

Souheaver, H.G., Benshoff, J.J., Wright, W.R. & Riggar, T.F. (1996). Aids knowledge among rehabilitation professionals. *Journal of Rehabilitation*.**62(2):** 2126.

Tsara BE, Zvinavashe M, Kasu CM, Gundani HV. Adherence to the PMTCT programme and perceived family support. *African j midwifery womens health.* 2011;5(1):5-8.

Tshibumbu D. Factors influencing men's involvement in prevention of mother to child transmission (PMTCT) of HIV programmes in Manbwe district, Zambia. *University of South Africa (UNISA)* 2006.

UNAIDS. (2000). HIV/AIDS in Africa UNAIDS fact sheets. [Online], Available: http:/www.unaids.org/fact-sheetsfiles/FS-Africa.html. [11/11/13 19:46.].

UNAIDS (2010). Global Report: UNAIDS report on the global AIDS epidemic/ 2010. Geneva, Switzerland; Joint United Nations Programme on HIV/AIDS (UNAIDS); 2010 retrieved April 18, 2013 from http://www.unaids.org/globalreport/documents/20101123_GlobalReport_full_en.pdf

UNAIDS. (2002). HIV voluntary counselling and testing: a gateway to prevention and care. Retrieved April 15, 2013, from Data.unaids.org/publications/IRC-pub02/sc729-vct-gateway-cs_en.pdf

Van Wissen, K.A. & Siebers, R.W.L. (1993). Nurses' attitudes and concerns pertaining to HIV and AIDS. *Journal of Advanced Nursing.* **18(6):** 912-7.

Wall K, Karita E, Nizam A, Bekan B, Sardar G, Casanova A, Joseph davey D, Clercq F, Kestelyn E, Bayingana R, Tichacek A, Allen S. (2012). Influence network effectiveness in promoting couples' HIV voluntary counselling and testing in Kigali, Rwanda. *AIDS*, 26*(2):217-227*

Wellings, K. & Wadowath, J. (1990). Aids and the moral climate in; Jowel, R., Witherspoon, S. & Brook, L. (eds). *British Social Attitudes.* Aldershat Government publishing.

Wicher, C. P. (1993). AIDS and HIV: The dilemma of the health care worker. *Journal of The American Association Of Occupational Health Nurses.* **41(6):** 282289.

Williams, E.S. & Kennedy, J. (1989). AIDS survey in Croydon-Attitudes, knowledge and opinions. *Journal of Health Education.* **48(1):** 24-26.

World Health Organization, (2007). *Engaging men and boys in changing gender – based inequality in health: evidence from programme interventions*. Geneva, Switzerland; world Health Organization; 2007

WHO. Global Health Sector Strategy on HIV/AIDS 2011-2015. 2011. who.int/hiv/topics/vct/en/ (publication 9789241501631). Accessed April 20, 2013.

Appendix 1: Consent Form

STELLENBOSCH UNIVERSITY

INFORMED CONSENT FORM TO PARTICIPATE IN RESEARCH

TITLE OF THE STUDY:

WOMEN'S ATTITUDES TOWARD THEIR PARTNERS' INVOLVEMENT IN ANTENATAL CARE AND PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV IN QUTHING DISTRICT, LESOTHO.

You are asked to participate in a research study conducted by Dr O. A. ABIODUN Bachelor of Dentistry (B.CH.D), Post Graduate Diploma in Management of HIV/AIDS from the Africa Centre of HIV/AIDS at Stellenbosch University. The study will be conducted in partial fulfilment of a Masters in Management of HIV/AIDS. You were selected as a possible participant in this study because of you is a nursing mother or because you are pregnant.

1. **PURPOSE OF STUDY**

The study is designed to identify pregnant women and nursing mother's attitude towards their partners' involvement in ante – natal care services and prevention of mother – to – child transmission of HIV in Quthing district of Lesotho. It is hoped that the study will help establish their attitude and identify the extent to which the antenatal care services supports male participation, and where possible offer recommendation towards encouraging male participation in ante-natal care services.

2. **PROCEDURES**

If you volunteer to participate in this study, we would ask you to do the following things: Respond to a questionnaire with 17 questions on your attitude and beliefs regarding antenatal care, beliefs about male participation, knowledge and attitudes about HIV/AIDS and women's perception of men's attending antenatal clinic.

3. POTENTIAL RISKS AND DISCOMFORTS

This study does not have any potential risks although discomforts may be experienced during responses to some questions. Further to this, participants will not be forced to share information that they are not comfortable to disclose and have the right to ask that certain information be omitted if they so wish.

In the event that any participant experiences discomfort, the researcher will stop the questions and allow for such information to be omitted. Depending on the circumstances, the researcher will avoid questions that may seem to cause discomfort to any participants and allow for withdrawal of participants where necessary.

4. POTENTIAL BENEFITS TO SUBJECTS AND OR TO SOCIETY

Potential benefits for participating in this study include enhancing the participant's knowledge of HIV/AIDS and modes of transmission. Participants will be able to contribute to the recommendation where possible on how male partners' could be encouraged to attend antenatal care services with their women and thereby benefit from its implementation thereafter.

5. PAYMENT FOR PARTICIPATION

While snacks and drinks will be provided to participants for the duration of the study, no allowances will be provided to participants as a payment.

6. CONFIDENTIALITY

Any information that is obtained in connection with the study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by ensuring that information collected from the subject will not be directly linked to individuals. Personal information will be obtained through anonymous questionnaires. If the need for counseling should arise, provision has been made for counseling services. The following registered counsellors will be on hand to offer counseling and psychosocial support.

Elelloang Damane (elledamane@yahoo.com; +266 58547438)

Moleboheng Mokhitli (molebohengmokhitli@rocketmail.com; +266 63206124)

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you do not want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

8. IDENTIFICATION OF INVESTIGATORS

If you have any question or concerns about the research, please feel free to contact Dr. O. A. Abiodun, Quthing Government Hospital, and Quthing, Lesotho. Tel +26659674818, Cell: +26657515171 e-mail:drabiodun@yahoo.com or if you have any questions or concerns regarding the research, please feel free to contact the supervisor of my study, Dr T. E. QUBUDA at tqubuda@sun.ac.za or +27 21 808 3999.

9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

The information above was described to…….. (Participant) by……in English/Sotho, and I am in command of the language or it was satisfactorily translated to. The participant was given the opportunity to ask question and these question were answered to his/her satisfaction.

I hereby consent voluntarily to participate in this study. I have been given a copy of this form

NAME OF PARTICIPANT

SIGNATURE OF PARTICIPANT

DATE

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to……. He/she was encouraged and given ample time to ask me any questions. This conversation was conducted in Sotho.

…… ……..

Signature of Investigator Date

Appendix 1: Foromo ea Tumellano

STELLENBOSCH UNIVERSITY

TUMELLANO E HLAKILENG EA HO NKA KARALO

LIPATLISISONH/BOITHUTONG

SEHLOHO SA LIPATLISISO/BOITHUTO:

MAIKUTLO A BASALI/BO - 'ME KA HO NKA KARALO HOA BALEKANE BA BONA TLINIKING EA BAKHACHANE LE THIBELO EA HIV HO TLO HA HO 'MA HO EA O LESEA "SEPETLELE SA QUTHING, LESOTHO"

O kopuoa ho nka karolo lipatlisisong/boithutong bo etsoang ke Dr O. A. ABIODUN Bachelor of Dentistry (B.CH.D), Post Graduate Diploma in Management of HIV/AIDS from the Africa Centre of HIV/AIDS at Stellenbosch University. Boithuto bona ke karalo ea ho phethela lengolo la Masters in Management of HIV/AIDS. O khethetsoe ho nka karolo hobane o le mokhachane kapa motsoetse.

1. **SEPHEO SA LIPATLISISO/BOITHUTO**

   Lipatlisio kapa boithuto bona bo e ntsoe ka sepheo sa ho fumana maikutlo a bakhachane le batsoetse, ka ho nka karolo hoa balekane ba bona "tliniking ea bakhachane" le ho tseba ha holoanyane ka "ts'oaetso ea 'm'a ho lesea" ka hara setereke sa Quthing, Lesotho. Tebello ke hore lipatlisiso kapa boithuto bona, bo tla fumana mekhoa le ka moo tliniki ea bakhachane e thoholetsang bo teng ba bo-ntate lits'ebeletsong le ho fana ka khothaletso ea hore bo-ntate ba be teng lits'ebeletsong tsa mofuta ona.

2. **MEKHOA EA TSAMAISO**

   Haeba o ithaopela ho nka karolo lipatlisisong kapa boithutong bona, ke kopa o etse lintho tsena tse latelang: Araba lipotso tse leshome le metso e supileng (17) ka maikutlo le tumelo ea hao mabapi le tliniki ea bakhachane, li-tumelo ka bo-ntate ba nkang karolo ho ts'eetsa balekane ba bona, tsebo le... ka HIV/AIDS le ka moo basali ba nkang banna ba eang tliniking ea bakhachane ka teng.

3. MENYATLA EA LITSIETSI LE HO SE PHUTHULOHE HOA BA NKILENG KAROLO BOITHUTONG BONA

Lipatlisiso kapa boiuthuto bona ha bona monyetla oa tsietsi kapa litsietsi empa ho ka ba le lihlong ho motho ha a araba lipotso tse ling tse itseng. Ho feta moo, ba nkileng karolo ba k eke ba qobelloa ho fana kapa ho arolelana litaba tseo bas a phuthuloheng ho li bolela hape ban a le tokelo ea hore litaba tse itseng li nts'oe ha ba lakatsa joalo.

Ha ho etsahala hore e mongo a ba nkileng karolo lipatlisisong/boithutong bona a utloe a sa phuthuloha, mofuputsi o tla emisa 'me taba ea mofuta oo etla fetoa. Ho latela boemo bo renang mofuputsi o tla leka ho qoba lipotso tse ka etsang batho bas a phuthuloheng kapa ho lamella ba batlang ho se tsoele pele ka liphuputso tseo ho lokoloha.

4. MELEMO BAKENG SA BA NKILENG KAROLO LIPATLISISONG/BOITHUTONG BONA LE HO SECHABA KA KAKARETSO

Melemo eo batho ba nkileng karolo lipatlisisong/boithuthong bona ba ka e fumanang e kaba ho tseba ha holoanyange ka HIV/AIDS le ka moo e ts'oaetsanang ka teng. Ba nkileng karolo bat la ba le monyetla oa ho etsa likhothaletso hore na bo-ntate ba ka thoholetsoa/khothatletsoa ho ea tliniling ea bakhachane le balekane ba bona joang 'me ba ka fumana molemo ka mora moo.

5. PATALA/MOPUTSO HO BA NKILENG KAROLO

Ha hona chelete e tla fuoa/patala batho bat la nka karolo lipatlisisong/boithutong bona, empa lijo tse bo bebe lit la bat eng hore ba je ha ho ntse ho etsoa boithuto.

6. LEKUNUTU

Litaba li fe kapa li fe tse fumanoeng ha ho ntse ho etsoa lipatlisiso, tse ka nyalangoang le uena, etla lula e le lekunutu, lit la phatlalatsoa feela ka tumello ea hao kapa ha molao/makhotla a rialo. Lekunutu le tla bolokoa ka hore ho se be le litaba tse nyalangoang le ban eng ba nkile karolo. Ha hona moo ba nkileng karolo bat la batloa boitsebiso ba bona ha araba lipotso tsena. Ha ho k aba le tlhoko ea tlhabollo, ho na le bahlabolli ba se ntse ba le teng ho u thus aka tlhabollo mme bona bat la u fa tlhabollo le ts'ehetso eohlo u ka e hlokang.

Elelloang Damane (elledamane@yahoo.com; +266 58547438)

Moleboheng Mokhitli (molebohengmokhitli@rocketmail.com; +266 63206124)

7. HO NKA KAROLO LE HO TSOA BOITHUTONG BONA

Motho ka mong a ka khetha ho nka kapa ho se nke karolo boithutong bona. Ha o ithaopa ho nka karolo, u ka boela oa tlohela nako eohle ho sena litla-morao tsa letho. Hape motho a ka khetha ho se arabe potso tseo a sa batleng ho nka karolo ho tsona empa a sala e ntse le setho sa boithuto bona. Ea e tsang lipatlisiso a ka onts'a boithutong bona ha ho hlaha mabaka a mo khanellang moo.

8. BOITSEBISO BA MOTHO EA ETSANG LIPATLISISO/BOITHUTO

Haona le lipotso kapa litletlebo ka boithuto/lipatlisiso tsena, letsetsa Dr. O. A. Abiodun, Sepetle sa 'Muso sa Quthing, Quthing, Lesotho. Tel+26659674818, Cell: +26657515171 e-mail:drabiodun@yahoo.com kapa ha u na le lipotso kapa litlhakisetso mabapa le lipatlisiso tsena u ka ikopanya le mookameli oaka eleng, Dr T. E. QUBUDA at tqubuda@sun.ac.za or +27 21 808 3999.

9. LITOKELO TSA BA NKILENG KAROLO BOITHUTONG/LIPATLISISONG TSENA

U ka khetha ho se nke karolo lipatlisisong tsena ka nako eohle. U na le tokelo ea ho etsa qoso ha u ka utloa lipatlisiso tsena li le khahlanong le litoelo tsa hau mme o ka khetha ho se tsoele pele ka ho nka karolo lipatlisisong tsena. Ha u na le lipotso khahlonong le litokelo tsa hau malebana le lipatlisiso tsena u ka bua le 'm'e Malene ho (mfouche@sun.ac.za; +27 21 808 4622) Karolong ea nts'etso pele ea lipatlisiso.

LEBITSO LA EA ETSANG LIPATLISIO KPA MOEMELI OA MOLAO

Litaba tse hlahang mona li hlaloselitsoe:…… (ea nkileng karolo) ke……ka Sekhoaa/Sesotho, li fetoletsoe kapa ho tolokoa ka Sesotho. Ea nkileng karolo o la fuoa monyetla oa ho botsa lipotso 'me li ile tsa arajeloa ho mo khotsofatsa.

Ke lumela ho nka karolo lipatlisisong/boithuto bona. Ke fuoe foromo ena ho e tlatsa.

LEBITSO LA EA NKILENG KAROLO

LEBITSO LA EA NKILENG KAROLO (TEKENA)

LETSATSI

LEBISTSO LA EA ENTSENG LIPATLISISO (TEKENA)

Ke pakahatsa mona hore litaba tse ngotsoeng mona ke li hlaloselitse:……. O ile a khothaletsoa le ho fuoa nako e lekaneng ho mpotsa lipotso. Puisano ena e entsoe ka sesotho.

…… ……..

Lebitso la ea entseng lipatlisiso (tekena) Letsatsi

Appendix 2: Consent Form

STELLENBOSCH UNIVERSITY

INFORMED CONSENT FORM TO PARTICIPATE IN RESEARCH

TITLE OF THE STUDY:

WOMEN'S ATTITUDES TOWARD THEIR PARTNERS' INVOLVEMENT IN ANTENATAL CARE AND PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV IN QUTHING DISTRICT, LESOTHO.

You are asked to participate in a research study conducted by Dr O. A. ABIODUN Bachelor of Dentistry (B.CH.D), Post Graduate Diploma in Management of HIV/AIDS from the Africa Centre of HIV/AIDS at Stellenbosch University. The study will be conducted in partial fulfilment of a Masters in Management of HIV/AIDS. You were selected as a possible participant in this study because of you are a staff of maternal and child health of Quthing district hospital.

1. **PURPOSE OF STUDY**

The study is designed to identify pregnant women and nursing mother's attitude towards their partners' involvement in ante – natal care services and prevention of mother – to – child transmission of HIV in Quthing district of Lesotho. It is hoped that the study may help establish their attitude and identify the extent to which the antenatal care services supports male participation, and where possible offer recommendation towards encouraging male participation in ante-natal care services.

2. **PROCEDURES**

If you volunteer to participate in this study, we would ask you to do the following things: You will be asked to participate in an individual interview with the researcher. This interview will take place at the department of maternal and child health of Quthing Government Hospital, during a suitable time or at a venue and time which is convenient for the participants. The interview will not last more than 60 minutes and will also be tape recorded for the purpose of

accurate data collection. Confidentiality, anonymity and privacy of data will be maintained at all times.

3. POTENTIAL RISKS AND DISCOMFORTS

This study does not have any potential risks although discomforts may be experienced during responses to some questions. Further to this, participants will not be forced to share information that they are not comfortable to disclose and have the right to ask that certain information be omitted if they so wish.

In the event that any participant experiences discomfort, the researcher will stop the questions and allow for such information to be omitted. Depending on the circumstances, the researcher will avoid questions that may seem to cause discomfort to any participants and allow for withdrawal of participants where necessary.

4. POTENTIAL BENEFITS TO SUBJECTS AND OR TO SOCIETY

Potential benefits for participating in this study include enhancing the participant's knowledge of HIV/AIDS and modes of transmission. Participants will be able to contribute to the recommendation where possible on how male partners' could be encouraged to attend antenatal care services with their women and thereby benefit from its implementation thereafter.

5. PAYMENT FOR PARTICIPATION

While snacks and drinks will be provided to participants for the duration of the study, no allowances will be provided to participants as a payment.

6. **CONFIDENTIALITY**

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of no names or personal identifiers will be recorded in any of the data collection tools. In reporting the results, care will be taken not to report results in a way that would enable any participants to be identified and/or stigmatized in their views. Data will be stored in a safe place at all times. The researcher and her supervisor will be the only

persons having access to the data. All data collected will be destroyed after successful completion of the thesis, for the purpose of which it was collected. The anticipated period is after one (1) year. As mentioned previously, all interviews will be tape recorded and the interviews will be transcribed verbatim, without making any reference to your name or personal identifiers. Confidentiality and anonymity will be maintained throughout.

The purpose of the study is for the completion of an MPhil degree in HIV and AIDS Management and due to the requirement of the publishing of a thesis, the data collected, analysed and interpreted in this study will be reported on. In the writing of the thesis, confidentiality, anonymity, and privacy of participants will be maintained at all times.

The data collected will only be used for the aforementioned purpose and will not be used in any way to evaluate your skills or work performance, or the performance of the department in general.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you do not want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

8. IDENTIFICATION OF INVESTIGATORS

If you have any question or concerns about the research, please feel free to contact Dr. O. A. Abiodun, Quthing Government Hospital, Quthing, Lesotho. Tel +26659674818 Cell: +26657515171 e-mail: drabiodun@yahoo.com. If you have questions or concerns regarding the research, please feel free to contact the supervisor of my study, Dr T. E. QUBUDA at tqubuda@sun.ac.za or +27 21 808 3999.

9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research

study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

The information above was described to…….. (Participant) by Dr O. A. ABIODUN in English and I am in command of the language or it was satisfactorily translated to. The participant was given the opportunity to ask question and these question were answered to his/her satisfaction.

I hereby consent voluntarily to participate in this study. I have been given a copy of this form

NAME OF PARTICIPANT

SIGNATURE OF PARTICIPANT

DATE

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to……. He/she was encouraged and given ample time to ask me any questions. This conversation was conducted in English and no translator was used.

…… ……..

Signature of Investigator Date

Appendix 3

QUESTIONNAIRE

WOMEN'S ATTITUDES AND BELIEFS REGARDING ANTENATAL CARE

1. **Women's reasons for antenatal care attendance**

Health problems are identified and can be treated ☐

To help determine if the foetus is alive and growing well ☐

To build up a good body and child ☐

To have more knowledge on self and type of diet ☐

Other

……

No reason given ☐

2. **What do you like best about antenatal care?**

Good lectures ☐

Good check-up ☐

The staffs are kind and supportive ☐

Clean environment ☐

Other:

---

3. **What do you like least about antenatal care?**

Unable to identify anything I do not like ☐

Long wait ☐

Other:

Staffs are rude and not helpful ☐

Dirty toilets ☐

Men checking women ☐

Did not wish to answer question ☐

Questions about women's beliefs

1. **Is it acceptable for a man to come to the antenatal clinic with his partner**

   Yes ☐
   No ☐
   Other:

   Did not wish to answer question ☐

2. **Why is it good for a man to come to the antenatal clinic?**

   Both can have HIV testing and know status together ☐
   To increase his knowledge of antenatal activities ☐
   In case of infection, they can be treated together ☐
   It shows real love and faithfulness for each other ☐
   It makes her happy and feel she is supported ☐
   The man will benefit from first-hand information ☐
   Other

   No reason ☐
   Did not wish to answer question ☐

3. **Why is it not good for a man to come to the antenatal clinic?**

   Many men do not have time to come ☐
   Pregnancy is a woman's affair ☐
   It is not our culture ☐
   Other

   No reason ☐
   The woman may be ashamed and uncomfortable ☐
   The health workers may not welcome him ☐
   His other wives will be jealous ☐
   Did not wish to answer question ☐

4. **What do most women in your village think about men who come to the antenatal clinic?** ☐

It is normal

It is not normal ☐

The man is jealous and overprotective ☐

It is an act of responsibility and true love ☐

It is a sign of weakness in the man ☐

Other

Did not wish to answer question ☐

Questions about Men's Attendance at Antenatal Clinic

1. **Has your partner ever come with you to the antenatal clinic?**

   Yes ☐

   No ☐

2. **Have you ever asked your partner to come to the antenatal clinic?**

   Yes ☐

   No ☐

3. **When you asked, did your partner accept?**

   Yes ☐

   No ☐

4. **If he did not accept, what did he say?**

   He did not have time ☐

   He said, "I do not have anything to do there" ☐

   He said, "It is not me who is pregnant" ☐

   He did not wish to answer me ☐

   Other:

   Did not wish to answer question ☐

5. **Why have you never asked your partner to come to the antenatal clinic?**

   I know he will never accept to come ☐

   He does not have time ☐

   He is not always around ☐

   He does not have anything to do there ☐

   His presence will make me feel uncomfortable ☐

   Other:

   Did not wish to answer question ☐

Questions about Women's Knowledge and use of HIV Care

1. **Have you heard of HIV/AIDS**

   Yes ☐

   No ☐

2. **Have you had PMTCT counselling in antenatal care**

   Yes ☐

   No ☐

3. **Have you had an HIV test**

   Yes ☐

   No ☐

4. **When did you have the HIV test**

   Only during pregnancy ☐

   Only when not pregnant ☐

   When pregnant and when not pregnant ☐

   Other:

   Did not wish to answer question ☐

5. **Has your partner ever had an HIV test**

   Yes ☐

   No ☐

   I do not know ☐

   Did not wish to answer ☐

LIPOTSO TSE AMANANG LE MEKHOA LE LITUMELO TSA BASALI MABAPI LE TLINIKI EA BAKHACHANE

4. **Mabaka a basali a ho ea tliniking ea bakhachane**

   Hore mathata a bophelo haholo a amanang le bokhachane, a lemohuoe a be a phekoloe ☐

   Ho hlahloba kholo le phetheho ea lesea ☐

   Ho aha ‘mele oa ka le oa lesea la ka e nepahetseng. ☐

   Hoba le tsebo e nepahentseng ka ‘mele oa ka le mefuta ea lijo e Ke tla mehang ho eja. ☐

Mabaka a mang:

_____

Haho lebaka le fanoeng ☐

5. Ke lintho li fe tseo o li ratang ka tliniki ea bakhachane?

Lithuto tsa bokhachane tse fanang ka leseli ☐

tlhahlobo e nepahetseng ☐

Bosebeletsi bo tsehetsang ka boitelo ☐

Sebaka se hloekileng ☐

Mabaka a mang:

---

6. Ke eng eo o sa e rateng ka tliniki ea bakhachane?

ke sitoa ho fumana ntho tse ke sa lirateng ☐

Ho ema nako e telele ☐

Mabaka a mang:

Bosebeletsi bo seng hantle hape bo sa fane ka thuso ☐

Matlo a boithuso a sa hloekang ☐

Bo- Ntate ba hlahlobang bo-'mé ☐

Ha hona karabo ☐

LIPOTSO TSE AMANANG LE LI-TUMELO TSA BASALI

5. Na ho bohlokoa hore molekane oa hau a ka tla le uena tliniking?

E ☐

Che ☐

Mabaka a mang:

Ha hona karabo ☐

6. Hobaneng ho le bohlokoa hore ntate/molekane a ka ea le uena tliniking ea bakhachane?

Bobeli re ka hlahlobela mafu a likobo ho kenyelletsa le HIV ☐

Ho mo ruisa tsebo litabeng tsa lesea le lebelletsoeng ☐

Ho phekoloa ha mmoho mafung a ts'oaetsanang ☐

Ke ponahatso ea lerato le botsépehi

E etsa mokhachane/'m'e a thabileng ka lebaka la tsehetso ea molekane ☐

Mabaka a mang

Ha hona lebaka ☐

Ha hona karabo ☐

7. Hobaneng ho se bohlokoa hore monna a ka ea le molekane tliniking ea bakhachane?

Boholo ba bo-ntate ha bona nako ea ho tla ☐

Bokhachane ke taba tsa bo-'m'e eseng bo-ntate ☐

Ha se moetlo oa rona ka ha e tsa bo-ntate ba ekang ba fokola ☐

Mabaka a mang:

Ha hona lebaka ☐

Mosali/molekane a ka nna ba lihlong kappa a sitoa ho phuthuloha ☐

Basebeletsi ba tsa bophelo ba ka nna ba se ke ba mo amohela ☐

Balekane ba bang ba hae ba ka nna ba ba mona ha a felehetsa e mong ☐

Ha hona Karabo ☐

8. Basali ba bang motseng ba nahana joang ka monna ea etelang tliniking ea bakhachane le molekane oa hae?

Ke ntho e tloaelehileng ☐

Ke ntho e sa tloaelehang ☐

Ke monna oa sebouleli ☐

Ke ponahatso ea lerato le boikarabello bo phethehileng ☐

Ke bokoala monneng/o jele phehla ☐

Mabaka a mang:

Ha hona karabo ☐

LIPOTSO TSE AMANANG LE HO EA LITTS'EBELETSONG TSA BAKHACHANE KE BO-NTATE

6. **Na molekane oa hau o kile a tla le uena tliniking ea bakhachane?**

   E ☐

   Che ☐

7. **Na u kile oa re molekane oa hau a tle le uena tliniking?**

   E ☐

   Che ☐

8. **Hau mokopa, na molekane oa hao o la lumela?**

   E ☐

   Che ☐

9. **Haeba o ile a hana, o ile a re mabaka ke afe?**

   Ha ana nako ☐

   O ile a re, "ha hona seo a ka se etsang moo" ☐

   O ile a re, "ha se eena eo e leng mokhachane" ☐

   Ha a ka a rata ho mpha karabo ☐

   Mabaka a mang:

   Ha hona karabo ☐

10. **Hobaneng o so botse/kope molekane oa hau ho tla le uena tliniking?**

    Ke a tseba a ke ke a lumela ho tla le 'na ☐

    Ha a na nako ☐

    Ha a fumanehe ha bonolo/Ha a lule a le teng ☐

    Ha hona seo a ka se etsang moo ☐

    Boteng ba hae bo tla etsa ke seke ka phuthuloha ☐

    Mabaka a mang:

    ☐

Ha hona karabo

LIPOTSO TSE AMANANG LE TSEBO EA BASALI KA HIV LE TLHOKOMELO KHAHLANONG LE TS'OAETSO EA HIV

6. **Na o kile oa utloa ka tsóaetso /lefu la HIV/AIDS?**

   E ☐

   Che ☐

7. **Na o kile oa etsetsoa tlhabollo tliniking ea bakhachane ka thibelo ea ts'oaetso ea 'ma ho ea ho lesea?**

   E ☐

   Che ☐

8. **Na o kile oa etsa tlhahlobo ea HIV?**

   E ☐

   Che ☐

9. **O entse tlhahlobo ea HIV neng?**

   Ha ke le 'meleng ☐

   Ha Ke se 'meleng ☐

   Ha ke le 'meleng le ha ke se 'meleng ☐

   Mabaka a mang:

   Ha hona karabo ☐

10. **Na molekane oa hao o kile a etsa tlhahlobo ea HIV?**

    E ☐

    Che ☐

    Ha ke tsebe ☐

    Ha hona karabo ☐

Appendix 4

Interview guide for staffs of maternal and child health

KNOWLEDGE AND ATTITUDES OF MCH STAFFS

1. PERSONAL INFORMATION/PROFILE

Instruction

Please fill in this form with your information

a. Gender male ( ) female ( )

Age: Which group do you belong to?

22 – 27	( )
28 – 33	( )
34 – 39	( )
40 and above	( )

Highest qualification attained

Diploma	( )
Degree	( )
Masters	( )

The total years of experience working in MCH

1 - 5	( )
6 - 10	( )

11 and above ( )

2. KNOWLEDGE

a. What would you say are the modes of transmission of HIV/AIDS? Probe

b. How would unborn child/ child contract HIV from the mother?

c. What would you say were the stages of HIV/AIDS?

d. In your opinion how should health professionals protect themselves from getting the infected?

e. What is PMTCT?

f. What are the most common combinations of antiretroviral drugs used lately?

g. What are some of the side effects of these drugs to pregnant women?

3 ATTITUDE

a. How do you feel about pregnant women/nursing mothers who are HIV positive?

b. What is your opinion about people who got infected through having sex?

c. How do you feel about treating HIV/AIDS patients?

d. Are you concerned about treating HIV positive pregnant women/nursing mothers? Probe, if yes, why? What are the concerns? How do you suggest having your concerns addressed?

e. Do you think HIV positive pregnant women/nursing mothers are entitled to the same care as any other patients? Why do you say so?

f. What would be your reaction if male partners attend antenatal care services with their women?

4 SOURCE OF INFORMATION

a. What and how is your source of information concerning the latest developments on HIV/AIDS and its transmission?

b. Tell me about your institutional library in the context of HIV/AIDS literature?

c. How adequate is your knowledge on HIV/AIDS

d. What areas would you like to receive more knowledge in?

e. Is there anything that you would like to discuss concerning the above topics?